

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County... MontgomeryCity or town... Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... 14 hrs. 35 min.

Hospital, institution, or street address where death occurred:

Suburban HospitalHow long in hospital or institution? 14 hrs. 35 min.

## 3. (a) FULL NAME

Infant Boy Ankars

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MaleWhiteNewborn

6. (b) Name of husband or wife.....

8. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

April 29, 1945 - @ 3 55 p.m.

8. AGE:

Years

Months

Days

If less than one day

14 hrs. 35 min.9. Birthplace Bethesda, Montgomery, Maryland  
(Town, county, and state)

10. Usual occupation.....

## 11. Industry or business

12. Name William Andrew Ankars13. Birthplace Herndon, Virginia14. Maiden name Margaret Elizabeth HALL15. Birthplace Round Hill, Virginia

16. Informant.....

## Address

17. CREMATION  
(Burial, cremation, or removal. Which?)Date thereof... May 1 1945  
(month) (day) (year)Cemetery or crematory SUBURBAN HOSPITALLocation 8600 Old Georgetown Rd. - BETHESDA MD18. Funeral director O. B. Salou, Death

## Address

19. 5/1 45  
(Date rec'd by registrar)Wm E. Jones  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... MontgomeryCity or town... Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Route #2 - Spring Lake Park

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH April 30, 1945 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1, 29, 1945 to April 30, 1945and that I last saw him ~~alive~~ on April 29, 1945

Immediate cause of death.....

Prematurity (5 months)

Due to.....

Due to.....

Other conditions..... none

(Include pregnancy within 8 months of death)

Major findings of operations..... none

Date of op. ....

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

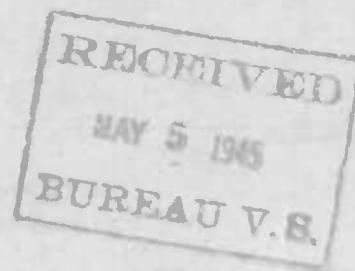
Means of injury.....

Injured at work?

23. SIGNATURE Wm G. Finkbeiner, M.D.

M. D. or other

Address Rockville, Md. Date signed 4/30/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

## CERTIFICATE OF DEATH

04934

223

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....

Montgomery County

City or town.....

Takoma Park Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

1 yr.

Hospital, Institution, or street address where death occurred:.....

100 - Westmoreland St

Now long in hospital or institution?.....

## 3. (a) FULL NAME

JOHN HENRY BAILEY

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M W Widowed

6. (b) Name of husband or wife.....

Mary F. Bailey

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

85 hrs. min.

9. Birthplace.....

Martin County N. CAROLINA

(Town, county, and state)

10. Usual occupation.....

FARMER

11. Industry or business

12. Name.....

JOHN H. BAILEY

13. Birthplace.....

N. CAROLINA

14. Maiden name.....

CHRISTINE LEEGETT

15. Birthplace.....

N. CAROLINA

16. Informant.....

FRANK W. BAILEY

Address

524 W. 31st. Norfolk, Va

17. Burial, cremation, or removal (Which?)

Burial

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

W. W. Shambus Co

18. Funeral director.....

1400 - Chapin St. N.W.

Address

April 9 1945

(Date rec'd by registrar)

Registrar

J. W. Morris, D.D.S.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

M.D.

County.....

Montgomery

City or town.....

TAKOMA PARK

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

100 - WESTMORELAND ST

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

4-8

1945

at 11:00

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/31/45 19

4/8

1945

and that I last saw him alive on

4/7/45

19

Immediate cause of death.....

cerebral hemorrhage

DURATION

Due to.....

Due to.....

Other conditions.....

seizures

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE.....

J. L. Marlow, M.D.

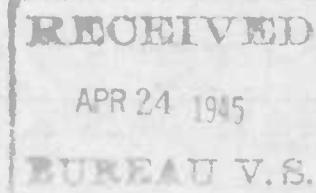
M. D. or other

Address.....

4601 Leland St

Date signed.....

4/9/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

04035

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County MontgomeryCity or town Jakoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Leo Gustave BarnardBarnard

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

married

6. (b) Name of husband or wife

Edna Barnard

7. Birth date of deceased (mo., day, yr.)

June 29 1895

6. (c) If alive, give age

20. DATE OF DEATH

April 22 1945 at 1:45 P.M.

8. AGE:

Years

Months

Days

If less than one day

49

7

23

hrs.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 19 Edna Barnard

19

19

and that I last saw her alive on

19

9. Birthplace

New York City

(Town, county, and state)

10. Usual occupation

executive

11. Industry or business

War Production Board

MOTHER FATHER

12. Name

Leon Barnard

13. Birthplace

France

14. Maiden name

Unknown

15. Birthplace

Portugal

16. Informant

Mrs Edna Barnard

Address

801 Garland Ave. Jakoma Park

17. Removal

Date thereof 4-22-1945

(month) (day) (year)

Cemetery or crematory

Washington D.C.

Location

W. W. Chambers

18. Funeral director

1400 - Chapin St. N.W.

Address

April 22 1945

19. (Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County MarylandCity or town Jakoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 801 Garland Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

World War II

## 3. (b) Social Security Number

082-16-3775

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 22 1945 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 19 Edna Barnard

19

and that I last saw her alive on

19

Immediate cause of death

coronary occlusion

DURATION

Due to

sudden

Due to

sudden

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Brossart M.D.Sup. Med. Examiner

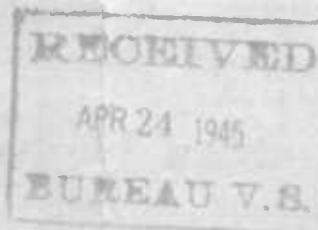
M. D. or other

Address

Elkridgeburg Md

Date signed

4-22-1945



M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 43-6

## CERTIFICATE OF DEATH

14036

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County.....

montgomery

City or town.....

Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

3 days

## 3. (a) FULL NAME

Mrs. Maude Barnes

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white widow

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

Sept. 13, 1878

8. AGE:

Years      Months      Days      If less than one day

66      7           hrs.      min.

9. Birthplace.....

Black Creek, N.C.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

12. Name.....

mattox

13. Birthplace.....

N.C.

14. Maiden name.....

?

15. Birthplace.....

N.C.

16. Informant.....

Roger L. Barnes (son)

Address

3914-7th St. N.E. Wash. DC

17. Disposition.....

Date thereof.....

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Wilson, N.C.

Location.....

North Carolina

18. Funeral director.....

Reuben Gumprecht

Address

7557 Wisconsin Ave. Bethesda

19. Date rec'd by registrar.....

Aug. 15 1945 N.E. 1000nd

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

montgomery

City or town.....

Brent Echo

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

103 Vassar Circle

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Apr. 13, 1945 at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1944 to April 13, 1945

and that I last saw her alive on April 13, 1945

Immediate cause of death..... Respiratory failure DURATION

Due to..... Carcinomatosis

Due to..... Cancer of the uterus

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

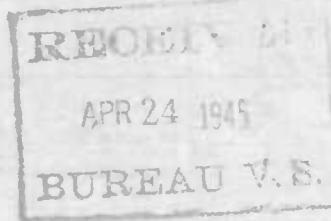
23. SIGNATURE.....

Frank Jaggers M.D.

M. D. or other

Address.....

8016 Georgetown Rd. Date signed 4/13/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4900

04037

## CERTIFICATE OF DEATH

216

Reg. Dist. No.

## 1. PLACE OF DEATH:

County... Montgomery

City or town... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

28 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

28 days

How long in hospital or institution?

## 3. (a) FULL NAME

BORK, Bessie May

## 3. (b) Social Security Number

4. Sex

female

5. Color or race

W-US

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife... Ch. Pharn. Frank Bork

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

26 April 1888

8. AGE:

Years  
57Months  
0Days  
4

If less than one day

hrs. .... min.

9. Birthplace... Texas

(Town, county, and state)

10. Usual occupation... housewife

## 11. Industry or business

12. Name... George Washington Roberts

13. Birthplace... Indiana

14. Maiden name... Henry May Barbour

15. Birthplace... Mississippi

16. Informant husband: Frank Robert Bork

Address 620 Ingraham St., N. W., Wash., D.C.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof... 5-2-45

(month) (day) (year)

Cemetery or crematory... Arlington National

Location... Arlington, Va.

18. Funeral director... Deal Funeral Home

Address 4812 Georgia Avenue, N.

19. April 30 1945 Mary Charlotte Smith

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D. C.

County...

City or town... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No... 620 Ingraham St., N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war...

## MEDICAL CERTIFICATION

20. DATE OF DEATH... April 30

1945, at 2:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2 April 1945, to 30 April 1945.

and that I last saw her alive on 30 April 1945.

Immediate cause of death...

carcinoma of ovary

DURATION

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE... M. R. Deddish S.P. (M) USN R

M. D. or other

Address... Naval Med. Center

Date signed... April 30

RECEIVED  
MAY 8 1945  
BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

04038

Reg. Dist. No.

716

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County

Montgomery

City or town

Bethesda, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

6 1/2 days

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

## 3. (a) FULL NAME

Mrs. Anna K. Brandt.

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married.

6. (b) Name of husband or wife

John Brandt

6. (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.)

Oct. 27, 1869

8. AGE:

Years

Months

Days

If less than one day

75

5

5

hrs.

min.

9. Birthplace

Conn.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Henry Mollenhauer

12. Name

Conn.

13. Birthplace

Conn.

14. Maiden name

Mary

15. Birthplace

Conn.

16. Informant

Mrs. Thomas Wilkins

Address

7007 Blendale, Ch. Ch. Md.

17. Burial

Cremation

(Which?)

Date thereof 4/2/45

(month) (day) (year)

18. Cemetery or crematory

Woodlawn Cemetery,

Location

New York City.

19. Funeral director

Eva Becker, Funeral Director

Address

7557 Wisconsin Ave., Bethesda, Md.

20. Date rec'd by registrar

4-2-45

19

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

D.C.

County

D.C.

City or town

Washington, D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

5429

Conn.

Ave.

apt. 304

(If rural, give LOCATION)

2.(a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

4/1/45

19

at 6:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/20

19

45

to 4/1

19 45

and that I last saw her alive on 3/31

19 45

Immediate cause of death

Cerebral Hemorrhage

DURATION

10 1/2 days

Due to

Cerebral arteriosclerosis

Due to

Other conditions

Hemiplegia

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Gretel B Rude M.D.

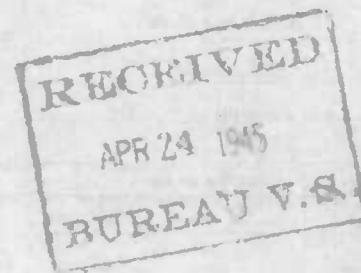
M.D. or other

Address

3900 Military Rd

Date signed

4/2/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

04639

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County ..... 6204 Vorlick La  
 City or town ..... Glen Echo, Montgomery Co., Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Ethel G. Brooks

4. Sex ..... 5. Color or race ..... 6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife ..... William H.

7. Birth date of deceased (mo., day, yr.) ..... Dec 10, 1879

8. AGE: Years ..... 65 Months ..... Days ..... If less than one day ..... hrs. ..... min.

9. Birthplace ..... Virginia (Town, county, and state)

10. Usual occupation:

## 11. Industry or business

12. Name ..... William F. Snider  
 13. Birthplace ..... Virginia14. Maiden name ..... Centruude Caylor  
 15. Birthplace ..... Virginia

16. Informant ..... William H. Brooks

Address ..... 6204 Vorlick La

17. Burial ..... 4/23/45  
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory ..... Cedar Hill Cemetery

Location:

18. Funeral director ..... The 8th Hines Co

Address ..... 2901-14th St. N.W.

4/21, 1945 (Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... Maryland County ..... Montgomery

City or town ..... Glen Echo (If outside city or town limits, write RURAL and give nearest town)

Street No. ..... 6204 Vorlick La (If rural, give LOCATION)

2. (a) If veteran, name war:

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH ..... April 20, 1945, at 10:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... January 19, 45, to April 20, 1945 and that I last saw her ..... alive on April 15, 1945.

Immediate cause of death ..... Chronic nephritis

DURATION

Due to:

Due to:

Other conditions ..... Diabetes mellitus

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

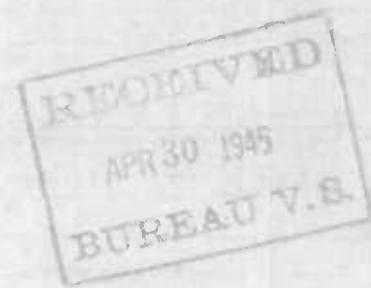
Injured at work?

23. SIGNATURE

J. Hammond M.D.

M. D. or other

Address ..... 1726 E. 48th N.W. Date signed ..... April 21, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13101

040410

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County Montgomery  
City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

500 Pershing Drive

How long in hospital or institution?

## 3. (a) FULL NAME

Mary E. Bryant4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Bert F. Bryant7. Birth date of deceased (mo., day, yr.) Feb. 5th. 1867 6. (c) If alive, give age years8. AGE: Years 78 Months 2 Days 25 If less than one day hrs. min.9. Birthplace Schenectady, N.Y.  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name JAMES A. FURBECK13. Birthplace New York14. Maiden name MARY M. BROOK15. Birthplace New York16. Informant Mrs. JAMES B. SHUTTS (daughter)Address 500 Pershing Drive  
17. Removal Removal Date thereof APRIL 30, 1975  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location FAIRACRES, MATAGORDA CO. TEXAS18. Funeral director Ward & HumphreyAddress 8434 Ga Ave - Silver Spring, Md.19. Date rec'd by registrar April 30 1975 Josephine M. Schaeffer

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 500 Pershing Drive  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1975 at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

March 24, 1975 to April 30, 1975 and that I last saw her alive on April 24, 1975

Immediate cause of death

Cerebral hemorrhageDue to Cardio vascular -  
renal diseaseDue to with hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

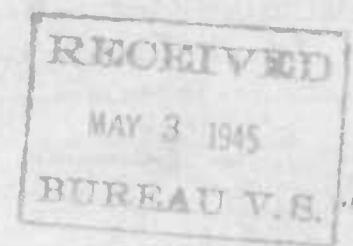
LYNWOOD HEIGHTS, M.D.

M.D. or other

Address 8040 PINEY BRANCH ROAD, N.W.Date signed 4/30/75

WASHINGTON, D.C.

TEL. 222-5250



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1861

04041

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

M

MARGIN RESERVED FOR BINDING

T

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County... *Maryland*City or town... *Baltimore, Md.*  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *Since April 15-43.*Hospital, institution, or street address where death occurred  
*Cedars of Lebanon Hospital*How long in hospital or institution? *Since April 15-43.*

## 3. (a) FULL NAME

*Martha Weaving Bushby*

4. Sex

5. Color of race

6. (a) Single, married, widowed, or divorced

*F* *White Widowed*

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age years

8. AGE: Years *68* Months  Days  It less than one day  hrs.  min. 9. Birthplace *Martinsburg, W. Va.*  
(Town, county, and state)10. Usual occupation *Housewife*

## 11. Industry or business

12. Name *Martha Weaving*13. Birthplace *Harper's Ferry, W. Va.*14. Maiden name *Catherine Elizabeth Bushby*15. Birthplace *Unknown*16. Informant *Mrs. Ruth W. Witt*Address *387 - 16th and Marion, Ohio*17. Burial Date thereof *May 7, 1945*  
(Burial, cremation, or removal. Which?) *Burial* (month) *May* (day) *7* (year) *1945*Cemetery or crematory *Rock Creek Cemetery*Location *Washington, D.C.*18. Funeral director *Martin W. Hesong Co.*Address *1300 - N. St. N.W. Washington, D.C.*19. Date *Apr. 29* 1945 *Josephine M. Scheff*  
(Do rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *D.C.* County *Washington, D.C.*City or town *Washington, D.C.*  
(If outside city or town limits, write RURAL and give nearest town)Street No. *1536 - Monroe Street*  
(If rural, give LOCATION)2.(a) If veteran, name war *✓*

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH *April 29* 1945 at *8 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*April 9* 1945 to *April 29* 1945and that I last saw her *alive* on *April 29* 1945

## Immediate cause of death

*Pneumonia, later, Terminal* DURATION *1 day*Due to *Fracture, right hip* 20 daysDue to *Progressive type of* *senile psychosis* 4 yrs.

Other conditions

(Include pregnancy within 8 months of death)

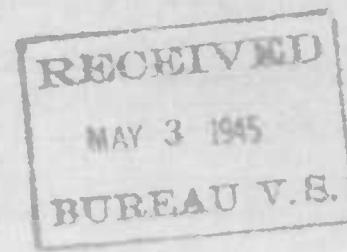
Major findings of operations *Fracture of rt. hip.* Date of op. *April 12-45*

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *accident* Date of *April 8-45*Where did injury occur? *Montgomery, Md.* (City or town) (County) (State)Injured at home, farm, industry, public place (where?) *Edgewood Sanatorium*Means of injury *Fall* Injured at work? *No*23. SIGNATURE *John Mitchell, M.D.* M. D. or otherAddress *Sierra Spring, Md.* Date signed *April 29, 1945*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (K)

04042

218

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....

Montgomery

City or town.....

Brooksville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

4 Mo.

Hospital, Institution, or street address where death occurred:

Brooksville

How long in hospital or institution?.....

## 3. (a) FULL NAME

Shirley Marie Carter

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female

colored

6. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

Dec 7 1944

6. (c) If alive, give age

years

8. AGE:

Years      Months      Days      If less than one day

4

1

hrs.

min.

9. Birthplace.....

Brooksville Md.

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

FATHER

12. Name..... John Henry Carter

13. Birthplace..... Brooksville Md.

MOTHER

14. Maiden name..... Marie Campbell

15. Birthplace..... Stewartstown Md.

16. Informant.....

Address

Bethesda, Maryland

17. Burial

(Burial, cremation, or removal. Which?) Cemetery or crematory.....

Date thereof..... 4-9-1945  
(month) (day) (year)

Location.....

Brooksville Md.

18. Funeral director.....

Roy W. Barber

Address

Pattersonville Md.

19. (Date rec'd by registrar)

19.....

Date rec'd by registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Montgomery

City or town.....

Raytownville Md.

Street No.....

(If outside city or town limits, write RURAL and give nearest town)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Apr 8 1945 at 5:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 15 1945 to Apr 7 1945  
and that I last saw h. it alive on Apr 7 1945

Immediate cause of death.....

Bronchopneumonia

DURATION

Due to.....

colds

Due to.....

-

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings at operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

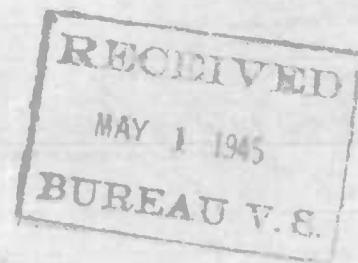
Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other  
Address.....  
Signature..... Date signed..... Apr 8, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (342)

04943

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH: Montg Co,  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 Mo.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Md. County..... Montg.,  
City or town..... Washington Grove,  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

## 3. (b) Social Security Number

Edith P Case

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced			
Female	White	Widow			
6.(b) Name of husband or wife		John W Case			
7. Birth date of deceased (mo., day, yr.)		6.(c) If alive, give age..... years			
8. AGE: Years	Months	Days	If less than one day		
1869	75	8	5	hrs.	min.
9. Birthplace.....		July 29th 1869			
(Town, county, and state)		(Town, county, and state)			
10. Usual occupation		House Wife			
11. Industry or business					
12. Name.....		Edward McMullan			
13. Birthplace		Va,			
14. Maiden name.....		Frances Piper			
15. Birthplace		Va,			
16. Informant.....		Mrs Geo. Stringfellow			
Address		Wakefield Va,			

17. Burial Date thereof..... 4/4/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Standardville Cemetery

Location..... Near Standardville Va,

Brickert & Miller

18. Funeral director..... Standardville. Va,

Address

19. April 3 1945 Abrahel G Cook  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 2nd 1945 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Oct - 25 1944 to April 2 1945  
and that I last saw her alive on Oct - 25 1944

## Immediate cause of death

Cardiac insufficiency  
Cerebral hemorrhage

Due to: High arterial tension

Due to: Chronic intestinal neoplasms

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

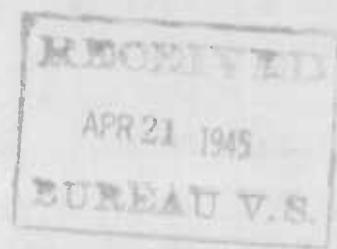
Injured at home, farm, industry, public place (where?)

## Means of Injury

Injured at work?

## 23. SIGNATURE

K. C. Miller, M.D.  
Address: Southbridge, Md. M. D. or other  
Date signed: 4/3/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-20

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

04844

## 1. PLACE OF DEATH:

County... Montgomery

City or town... Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Suburban Hospital

How long in hospital or Institution?

29 days

## 3. (a) FULL NAME

Harry W. Chadduck

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ada B. Chadduck

7. Birth date of deceased (mo., day, yr.)

June 22, 1873

6. (c) If alive, give age 67 years

8. AGE:

Years  
71Months  
9Days  
13

If less than one day

hrs. min.

9. Birthplace

Crawfordsville, Indiana

(Town, county, and state)

10. Usual occupation

Banker

11. Industry or business

MOTHER

12. Name Charles Chadduck

FATHER

13. Birthplace Virginia

MOTHER

14. Maiden name Frances Webster

FATHER

15. Birthplace Virginia

16. Informant

Harry Chadduck, Jr.

Address

4820 Bradley Blvd.

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof 11/4/45  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address 2901-14 St NW

19. 4/4

(Date rec'd by registrar)

1845

2pm 5 Dec 45

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland

County... Montgomery

City or town... Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5600 Edgemoor Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 4<sup>th</sup> 1945 at 1:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 15, 1945, to April 4, 1945

and that I last saw him alive on April 3, 1945

Immediate cause of death

Malignant carcinoma of the

secondary one year

Due to Cancer of large bowel

DURATION

4 months

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: Colostomy &amp; large bowel resected about 8 months ago Date of op. April 1945

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Bruce Benjamin M.D.

M. D. or other

Address Bethesda, Md. Date signed 4/4/45



M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 831

04045

## CERTIFICATE OF DEATH

Reg. Dist. No. 716

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1 1/2 yrs.

Hospital, Institution, or street address where death occurred:

4534 Middleton St.

How long in hospital or institution?

## 3. (a) FULL NAME

Mr. Reuben H. Chambers.

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married

6. (b) Name of husband or wife

Pauline B.

7. Birth date of

deceased (mo., day, yr.)

Mar. 11, 1892

8. AGE:

Years Months Days If less than one day

53 1 4 hrs. min.

9. Birthplace

Kentucky

(Town, county, and state)

10. Usual occupation

Salesman

11. Industry or business

Chas. W. Chambers.

12. Name

Indiana

13. Birthplace

Tillian Hemingway

14. Maiden name

Kansas

15. Birthplace

Pauline B. Chambers

16. Informant

Address 4534 Middleton St.

17. Burial, cremation, or removal, which?

Date thereof 4/15/45

(month) (day) (year)

Cemetery or crematory

Oakwood Cemetery

Location Richmond, Va.

18. Funeral director

C. Reuben Chambers

Address 7557 Wisconsin Ave. Bethesda,

19. (Date rec'd by registrar) 4/14 1945

(Date signed) 4/14/45

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. County Montg.

City or town

Bethesda, Md. (If outside city or town limits, write RURAL and give nearest town)

Street No.

4534 Middleton St. (If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

2D. DATE OF DEATH 4/14/45 19 at 7A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 13 1945 to Apr. 14 1945

and that I last saw him alive on Apr. 13, 1945

Immediate cause of death

Cerebral embolism

DURATION

2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. G. Baerfield, Jr.

M. D. or other

Address Bethesda, Md. Date signed 4/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 470

04046

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County. Montgomery

City or town. Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 13 days

## 3. (a) FULL NAME

CHANDLER, James Austin V. B. P.

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

W-US

W-US

Married

6.(b) Name of husband or wife.....

Mrs. Julia C. Chandler

7. Birth date of deceased (mo., day, yr.)

2-19-93

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

South Carolina

(Town, county, and state)

10. Usual occupation.....

retired from service

11. Industry or business.....

MOTHER FATHER

12. Name..... James C. Chandler

13. Birthplace..... South Carolina

14. Maiden name..... Agnes Austin

15. Birthplace..... South Carolina

16. Informant..... Wife: Mrs. Julia C. Chandler

Address 47 Centennial St., Clinton, S. C.

17. Removal.....

(Burial, cremation, or removal. Which?) Date thereof..... 4-8-45

(month) (day) (year)

Cemetery or crematory.....

Location..... Clinton, S. C.

18. Funeral director..... W. W. Chambers

Address George town, St., Washington, D.C.

19. April 8

1945

(Date rec'd by registrar)

Mary Elizabeth Smith

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State. South Carolina County.....

City or town. Clinton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 17 Centennial Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 8 April 1945

19

at 0925 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

24 Feb.

19 45

to 8 April

19 45

and that I last saw h. im alive on

7 April

19 45

Immediate cause of death.....

Carcinoma (Squamous)  
Bronchus (R.)

DURATION

Due to..... arterio-sclerosis

Unknown  
Unknown

Due to..... Myocarditis, Chronic

Unknown

(Include pregnancy within 3 months of death)

Major findings of operations..... Carcinoma, Bronchus R.

Date of op. 4 April 1945

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

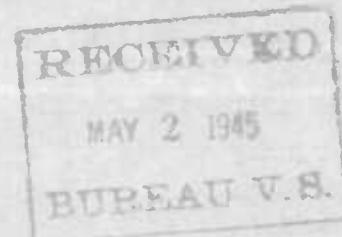
Injured at work?

23. SIGNATURE E. M. KENT, Lt. Cond. (MC) USNR

M. D. or other

USNH Bethesda, Md.

Date signed 4-8-45



VS A15  
T  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of  
year of birth of deceased  
is shown on  
FILM NO. G 95 JUN 5 1945

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3

## CERTIFICATE OF DEATH

04047

Reg. Dist. No.

716

## 1. PLACE OF DEATH:

County MONTGOMERY  
City or town BETHESDA  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

HARRY KING CORNWELL

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MWMARRIED

6. (b) Name of husband or wife

DOROTHEA POPE

6. (c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) OCT 10/1887 1886

8. AGE:

Years

Months

Days

If less than one day

.....hrs. .....min.

9. Birthplace.....NEW YORK STATE

(Town, county, and state)

10. Usual occupation.

RETIRED

11. Industry or business

12. Name SAMUEL G. CORNWELL13. Birthplace CHATHAM N.Y.14. Maiden name SOPA MARSH15. Birthplace KAMMAY NJ16. Informant ELICE H. CORNWELLAddress 1919 35TH NW. WASHINGTON17. Burial.....Burial Date thereof 4/1/45  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory New York StateLocation NEW YORK STATE18. Funeral director Joseph Gavles SonAddress 1756 - Pa. Ave NW19. 4/4 1945 7pm E Jobeck  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State MD County MONTCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5000 - Edgemore Lane  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1945 al 8:49A21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 1941 to April 4 1945 and that I last saw h. alive on April 3 1945

Immediate cause of death

congestive heart failure

DURATION

2 daysDue to arterio sclerosisHypertension10 years10 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

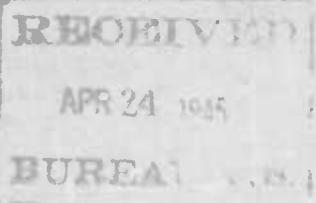
Injured at work?

23. SIGNATURE

Leibit B. Rude

M. D. or other

Address 3900 Military Rd N Date signed 4/5/45



✓ Evidence for change of  
birth date of deceased &  
age is shown on

FILM NO. G 95 JUN 1 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

CERTIFICATE OF DEATH

Reg. Dist. No.

223

04048

1. PLACE OF DEATH: MONTGOMERY

County

City or town TAKOMA PARK

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred: Jolliffe Rest Home

How long in hospital or institution? 2 years

3. (a) FULL NAME

LAURA

4. Sex

F

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

W.

6. (b) Name of husband or wife: —

7. Birth date of

deceased (mo., day, yr.) Nov 18 1866

6. (c) If alive, give age years

8. AGE:

80 79

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace: Penn

(Town, county, and state)

10. Usual occupation: Retire

11. Industry or business: —

MOTHER FATHER

12. Name: Isabella

13. Birthplace: Penn

14. Maiden name: Hannah Koon

15. Birthplace: Penn

18. Informant: Mary and Harry Lerner

Address: 410 Carolina Place

17. (Burial, cremation, or removal. Which?) Date thereof: April 16, 1945

(month) (day) (year)

Cemetery or crematory: Arlington National

Location: Virginia

18. Funeral director: Joseph Lawless Son

Address: 175 1/2 Pa. Ave., NW

19. (Date rec'd by registrar) April 13 1945

(Date rec'd by registrar) April 13 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: DC

County

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5911 - 31st Place NW

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

COX

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 13 1945 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1942 to 1945, and that I last saw her alive on Apr 13 1945

Immediate cause of death: Arterial hypertension

Cardiac decompensation

Due to: Arteriosclerosis

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings or operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

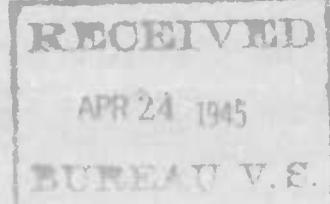
Meane of injury: —

Injured at work? —

23. SIGNATURE: John Hogan MD

M. D. or other

Address: 600 N. Woods St. NW Date signed: Apr 13 1945



PLEASE WRITE PLAINLY, WITH ~~CONFADING~~ INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

04049

216

## 1. PLACE OF DEATH:

County: MontgomeryCity or town: Bethesda - Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 days

Hospital, Institution, or street address where death occurred:

Suburban HospitalHow long in hospital or Institution? 25 days

## 3. (a) FULL NAME

Walter Cross

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male NegroSeparated

## 6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

Feb. 2-18-69

## 8. AGE:

Years

Months

Days

If less than one day

76-219

hrs.

min.

## 9. Birthplace

Virginia

(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

Thomas Cross

MOTHER / FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial!

(Burial, cremation, or removal. Which?)

Date the 25 (month) April (day) 1945 (year)

Cemetery or crematory

Lyon Wealey

Location

Coloma & yard

18. Funeral director

Robert A. Crossen

Address

246-71. Wash. St Rockville19. 4/25 1945 Wm E. Jones Registrar  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: MontgomeryCity or town: Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 21 1945 at 9:25

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 27 1945 to April 21 1945and that I last saw him alive on April 21 1945Immediate cause of death Renal decompensation

(uremia)

DURATION

1 weekDue to Renal tract infection,  
secondary to bladder paralysis 3 weeksDue to Torsades myelitis  
of spinal cord 1 moOther conditions Syphilis Several years

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M.D. or other

Address 726 Eye St. N.W. Washington D.C. Date signed Apr 15



M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 922

04650

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County Maryland

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One month and eight days

Hospital, institution, or street address where death occurred:

Washington Sanitarium and Hospital

How long in hospital or institution? one month and eight days

## 3. (a) FULL NAME

Gladys A. Droege

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Fe

white

married

6. (b) Name of husband or wife John A. Droege

7. Birth date of deceased (mo., day, yr.) May 24, 1900 6. (c) If alive, give age 75 years

8. AGE: Years Months Days If less than one day  
44 10 29 hrs. min.9. Birthplace New York City, New York  
(Town, county, and state)

10. Usual occupation House wife

## 11. Industry or business

12. Name ANDREW KING

13. Birthplace N.Y.

14. Maiden name LAURA HALE

15. Birthplace NEW YORK

16. Informant Washington Sanitarium Hospital Records

Address Takoma Park, Maryland

17. REMOVAL Date thereof APR 20 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory EVERGREEN

Location BROOKLYN - N.Y.

18. Funeral director WARDER F. PUMPHREY

Address 8435 Ga Ave. SILVER SPRING MD

19. 4/18 1945 J. Helen Droege  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring, Md. 20910

Street No. RFD #2

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1945 at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1945 to April 22, 1945  
and that I last saw her alive on April 22, 1945

Immediate cause of death

Left heart failure

DURATION

2 mo.

Due to Subacute Bacterial Endocarditis

4 mo.

Due to

Other conditions Rheumatic Heart Disease 25 yrs.  
Mitral Stenosis  
(Include pregnancy within 3 months of death)

Major findings or operations

Autopsy results Vegetative endocarditis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Carroll Ave Date signed 22 Apr 45  
Takoma Park, Md.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

598  
04051  
Reg. Dist. No. 216

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County

Montgomery

City or town

3 East Daveness Driveway

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

16 yrs

Hospital, Institution, or street address where death occurred:

3 East Daveness Driveway, North Chevy Chase

How long in hospital or institution?

## 3. (a) FULL NAME

Isabelle Mason Eaton

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white married

6. (b) Name of husband or wife

Herbert Nelson

7. Birth date of deceased (mo., day, yr.)

November 13, 1894

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Milford, Mass.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Walter Frank Mason

12. Name

Milford, Mass.

13. Birthplace

14. Maiden name

E. Edna Hilton

15. Birthplace

Mass.

16. Informant

Herbert Nelson Eaton.

Address

Same as above

17. Burial

Shipment

Date thereof 4/17/45  
(month) (day) (year)

(Burial, cremation, or removal, which?)

One Stone Cem.

Cemetery or crematory

Location

Milford, Mass.

18. Funeral director

Edw. Ranken Humphrey

Address

7557 Wisconsin Ave. Bethesda, Md.

19. Date rec'd by registrar

4-17-45

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Montgomery

City or town

North Chevy Chase, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

3 East Daveness Driveway

(If rural, give LOCATION)

(2. (d) If veteran, name war)

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

Apr. 15, 1945, at 2:05 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dp. Med. Examiner to 19.

and that I last saw h alive on 19.

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Bischach M.D.

D.P. Med. Examiner M.D. or other

Address 110th Street, Md. Date signed 4-15-45

RECEIVED

APR 24 1945

BUREAU F. B. I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04652

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

## 1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda, (Rural)

(If outside city or town limits, write RURAL and give nearest town)

45 Minutes

How long in above place of death?

Hospital, institution, or street address where death occurred:

USNH Bethesda, Md.

How long in hospital or institution? 45 Minutes

## 3. (a) FULL NAME

John Yates ELKINTON, CCS USN Ret. Inact.

## 3. (b) Social Security Number

## 4. Sex

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

male

White

Married

6. (b) Name of husband or wife..... Sussan Elkinton

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

Jan 13 1891

## 8. AGE:

Years

Months

Days

If less than one day

54

2

18

hrs.

min.

9. Birthplace..... Delaware

(Town, county, and state)

10. Usual occupation..... U. S. Navy

11. Industry or business..... Retired

MOTHER FATHER

12. Name..... Dave ELKINTON

13. Birthplace..... Del.

14. Maiden name..... Heddie ROBINSON

15. Birthplace..... Del.

16. Informant..... Wife: Mrs. Sussan Elkinton

Address..... 7805 Fort Foot, Anacostia, Wash., D.C.

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof..... 1-1-45

(month) (day) (year)

Cemetery or crematory..... Arlington National

Location..... Arlington, Va.

18. Funeral director..... W. W. CHAMBERS

Address..... 517 11th St., S. E., Wash., D.C.

19. 4-2-45

(Date rec'd by registrar)

Mary Charlotte Smith

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Dist. of Columbia

County.....

City or town..... Anacostia, D. C. Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 7805 Fort Foot

(If rural, give LOCATION)

2.(a) If veteran, name war..... ✓

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 1 1945

at 6:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Def. Med. Exam. case 19 10 19

and that I last saw h..... alive on 19

19

Immediate cause of death.....

Coronary occlusion

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

Frank J. Beorchard M.D.

M. D. or other

Address..... Harknessburg, Md. Date signed..... 4-1-45

RECEIVED TO THE SECRETARY OF STATE  
BY THE SECRETARY OF STATE  
RECEIVED TO THE SECRETARY OF STATE  
BY THE SECRETARY OF STATE

RECEIVED  
MAY 2 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH **INK**. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95

04053

## CERTIFICATE OF DEATH

Reg. Dist. No. 2/2

## 1. PLACE OF DEATH:

County

Montgomery Co

City or town

Martinsburg near Dickerson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

145 yrs

Hospital, Institution, or street address where death occurred.

How long in hospital or institution?

## 3. (a) FULL NAME

Sarah C. Fairfax

4. Sex

Female Colored Widowed

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

Deceased

7. Birth date of

deceased (mo., day, yr.)

6.(c) If alive, give age years

8. AGE:

55

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Poolesville Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Frank Johnson

13. Birthplace

Montgomery Maryland

14. Maiden name

Mary Counter

15. Birthplace

Montgomery Maryland

16. Informant

Edna M. Dorsey

Address

Dickerson Maryland

17. Burial

Burial

(Burial, cremation, or removal. Which?)

Date thereof April 29, 45

(month) (day) (year)

Cemetery or crematory

Martinsburg Md

Location

Near Dickerson

18. Funeral director

Clarence H. Davis

Address

Poolesville Md

19. Date rec'd by registrar

Apr. 27, 1945

19

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1945, at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/12, 1944, to April 25, 1945

and that I last saw her alive on April 25, 1945

Immediate cause of death

Cardiac Decomposition

DURATION

6 hrs

Due to arteriosclerosis

3 yrs

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

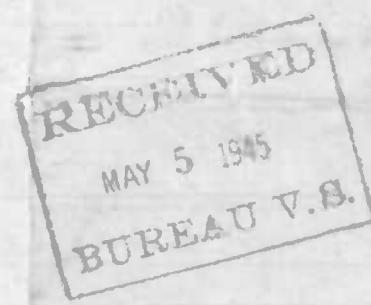
Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Bryan &amp; White, M.D.

M. D. or other

Address Parkville, Md Date signed April 27, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

Reg. Dist. No. 04954 216

## 1. PLACE OF DEATH:

County 20 Winston Drive, Montgomery Co.  
 City or town Country Club Village, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Orrin Harvey Farr

## 4. Sex

## 5. Color or race

## 6.(a) Single, married, widowed, or divorced

male

white

married

6.(b) Name of husband or wife Fannie Christie

## 7. Birth date of deceased (mo., day, yr.)

October 21, 1889

6.(c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

55

hrs.

min.

9. Birthplace Bristol, Vermont

(Town, county, and state)

10. Usual occupation Secretary

11. Industry or business Senator Myers of La.

George W. Farr

Lincoln, Vt.

12. Name George W. Farr

MOTHER FATHER

13. Birthplace Lincoln, Vt.

Bertha Atkins

15. Birthplace Lincoln, Vt.

16. Informant Mrs. Fannie Christie Farr

Address 20 Winston Drive, Columbia Club  
Village, Md.

17. removal

Date thereof (month) (day) (year)

Cemetery or crematory

Location Washington, D. C.

18. Funeral director The S. &amp; J. Dimes Co.

Address 2901 14th St. N.W.

19. 4/18/46

19. 46

Wm E. Jones

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Montgomery

City or town Country Club Village

(If outside city or town limits, write RURAL and give nearest town)

Street No. 20 Winston Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

April 18 1946 at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1938 1946 April 18 1946

and that I last saw him alive on April 18 1946

Immediate cause of death

Acute Coronary Declines 4 hrs

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

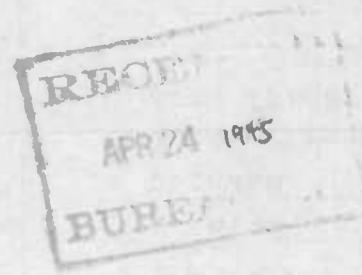
Injured at work?

## 23. SIGNATURE

Russell George M.D.

M. D. or other

Address 1801 Eye St. Date signed 4-18-46



PLEASE WRITE PLAINLY, WITH UNRAZING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04955

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County, Montgomery  
City or town, Oney, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital  
157 days.

How long in hospital or institution?

## 3. (a) FULL NAME

Mr. Garrett Fitzgerald

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MaleWhiteWidowed.6. (b) Name of husband or wife MARY - A.

7. Birth date of

deceased (mo., day, yr.)

April 26, 1875

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

69119hrs.min.

9. Birthplace

Washington, D. C.

(Town, county, and state)

10. Usual occupation RETIRED ENGINEER

11. Industry or business

D. C. Schools

MOTHER FATHER

Thomas FitzgeraldIreland.

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

Bridgett HoganIreland.

16. Informant

Hospital records

Address

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof ARR - 9 - 45

(month) (day) (year)

Cemetery or crematory

ST JOHNSLocation FOREST CHEN - MONTG. CO. MD18. Funeral director Warren & HumphreyAddress 8434 - Ga Ave - Silver Spring MD19. 4 - 7 - 1945 Gertrude B. Lawler  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State, Maryland Coony, MontgomeryCity or town, Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 200 Easley St

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 151945, at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 31 1945, to April 5 1945and that I last saw him alive on April 5 1945Immediate cause of death acute myocarditis

DURATION

4 weeksDue to Cardiac Failure

1 day

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

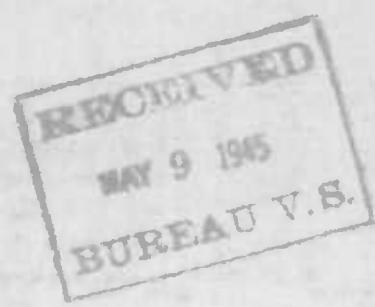
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Sandy Spring MD Date signed 4/5/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2

04056

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Carolyn Louise Flinchum

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F W Infant

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE: Years

Months

Days

If less than one day

hrs. min.

07 21

9. Birthplace

(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

Ralph L. Flinchum

Va

12. Name

Leigh Skinner

13. Birthplace

3322 - 9th St. N.E. D.C.

14. Maiden name

Burke

Date thereof 7-17-45  
(month) (day) (year)

15. Birthplace

Arb. Natl. Cemetery

16. Informant

Carolyn Louise Flinchum

Address 3322 - 9th St. N.E. D.C.

17. (Burial, cremation, or removal, which?)

Cemetery or crematory

Location Ft. Meyer - Va

18. Funeral director

WW Chambers Co.

Address Riverdale Md.

19. (Date rec'd by registrar)

Apr. 17 1945 Josephine M. Schaeffer

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

City or town

Street No.

County

City or town

Street No.

County

City or town

Street No.

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 15 1945 at 9:30 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from on April 14, 1945 (Cause of visit only) and that I last saw her alive on April 14, 1945. 19

Immediate cause of death

Bronchopneumonia

DURATION

24 hrs.

Due to

Acute Bronchitis

several days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Hannibal Heiges, M.D. M.D. or other

Address 650 Piney Br. Rd. N.W. Date signed 4/15/45

Wash. D.C.

RECEIVED  
MAY 3 1945  
BUREAU U.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

04057

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda, (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... one month &amp; four days

Hospital, Institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution?..... one month &amp; four days

## 3. (a) FULL NAME

GARRETT, Franklin Bond, Lt. Col. USMC Ret. Inact

## 3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	W-US	married

6. (b) Name of husband or wife..... Mrs. Lydia Garrett

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1877

8. AGE: Years	Months	Days	If less than one day
67	4	20	hrs. .... mils.

9. Birthplace..... La. (Town, county, and state)

10. Usual occupation..... Retired Lieutenant-Colonel

11. Industry or business..... United States Marine Corps

12. Name..... Franklin Garrett

13. Birthplace..... La.

14. Maiden name..... Elizabeth Bond

15. Birthplace..... La.

16. Informant..... Wife: Mrs. Lydia Garrett

Address..... 55 Woodmont Road, Alexandria, Va.

17. Burial..... Date thereof..... 1-28-15  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Arlington National

Location..... Arlington, Va.

18. Funeral director..... S. H. HINES, *S.H.H.*

Address..... 2901 14th St., N. W., Wash., D.C.

19. *afel ab*..... 19. 45..... *manchardt & smith*  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Va. County.....

City or town..... Alexandria

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 55 Woodmont Road

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 26 April 1945 at 11:40 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 March 1945, to 27 April 1945

and that I last saw him alive on 27 April 1945

Immediate cause of death.....

*Coronary Thrombosis*

DURATION

3 mos.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results..... *None done*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

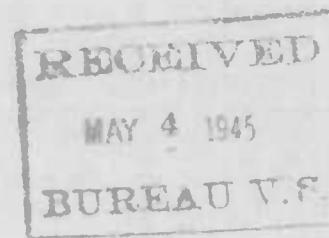
Injured at home, farm, Industry, public place (where?) .....

Means of injury.....

Injured at work? .....

23. SIGNATURE..... *Caleb O'Connell, M.D.* M.D. or other

Address..... 55 Woodmont Ct., Bethesda, Md. Date signed 4/26/45



✓ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 592

64658

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County.....

City or town.....

Montgomery

Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hosp.

How long in hospital or institution?

23

## 3. (a) FULL NAME

William W Georges

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male not Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Feb. 14, 1865

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

(Town, county, and state)

Washington DC

10. Usual occupation.....

-

11. Industry or business.....

-

12. Name.....

John S. Georges

13. Birthplace.....

Germany

14. Maiden name.....

Georges

15. Birthplace.....

Germany

16. Informant.....

Hosp. Records

Address.....

17.

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Removal

Location.....

The St. Hines Co

18. Funeral director.....

2901-14th St

Address.....

4/1 1945

91<sup>st</sup> E Jones

19. (Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

Wash DC

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

3327 - Stay rosent Blvd

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

April 1

1945 at 3:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 10

1945 to

April 1 1945

and that I last saw him alive on April 1 1945

Immediate cause of death.....

Gardian Detox

DURATION

30 months

Due to: Jackins Bedd Abscess

Generalized Enteric Disease

1 month

6 years

Due to.....

Other conditions: Gastroenteritis

15 years

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

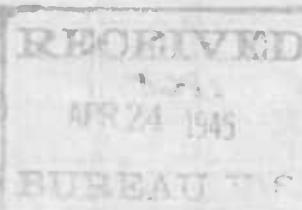
23. SIGNATURE.....

W.B. Wardrop MD

M. D. or other

Address: 943 Boundary St. Silver Spring

Date signed April 1, 1945



PLEASE WRITE PLAINLY, WITH UNLOADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1102

04659

Reg. Dist. No. 218

## CERTIFICATE OF DEATH

1. PLACE OF DEATH: Clautzamery  
 County Carroll  
 City or town Clarksburg, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? shortly  
 Hospital, Institution, or street address where death occurred:

Now long in hospital or institution?

## 3. (a) FULL NAME

Paul Grimes

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife none

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1928 6. (c) If alive, give age years

8. AGE: Years 17 Months 7 Days 24 If less than one day  
 hrs.  min.

9. Birthplace Adams Co., Pa.  
 (Town, county, and state)

10. Usual occupation laborer

## 11. Industry or business

MOTHER FATHER Daniel J. Grimes

12. Name Spouse dead

13. Birthplace Marshall Co., Wis. hope

14. Maiden name Mary E. Bishop

15. Birthplace Frankfort, Pa.

16. Informant Daniel J. Grimes

Address Gettysburg, Pa.

Burial, cremation, or removal. Which? Burial Date thereof 4-15-45 (month) (day) (year)

Cemetery or crematory Mountain View Cemetery

Location Clarksburg, Md.

18. Funeral director W. Milton Bender

Address Gettysburg, Pa.

19. April 11, 1945 Edward G. Cooke  
 (Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa. County Carroll

City or town Gettysburg, Pa.  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 154 Frederick St.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 11, 1945 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep. Med. Exam. case to 19

and that I last saw h. alive on 19

Immediate cause of death

Respiratory failure

Due to Fracture of 2nd cervical

vertebra with trauma

of cord (accidental)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 4-11-45

Where did injury occur? Clarksburg, Monts. (City or town) (County) (State)

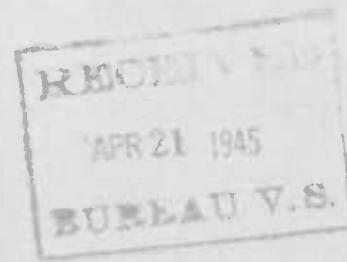
Injured at home, farm, industry, public place (where?) highway

Means of injury auto accident Injured at work? no

23. SIGNATURE Frank J. Brookhart M.D.

24. M. D. or other Dep. Med. Exam.

Address Gettysburg, Md. Date signed 4-11-45



M

MARGIN RESERVED FOR BINDING

T

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

04660

214

Reg. Dist. No.

## 1. PLACE OF DEATH:

County MONTGOMERY

City or town SILVER SPRING

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

602 DEERFIELD AVE.

How long in hospital or institution?

## 3. (a) FULL NAME

Mary Elizabeth Hammaros

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife Thomas B Hammaros.

7. Birth date of deceased (mo., day, yr.)

April 2nd 1901.

6. (c) If alive, give age

years

8. AGE:

Years 44

Months 0

Days 19

If less than one day

hrs. min.

9. Birthplace

Maryland.

(Town, county, and state)

10. Usual occupation

Housewife.

11. Industry or business

12. Name John E Plummer

13. Birthplace Maryland.

14. Maiden name Cora Taylor

15. Birthplace Maryland.

16. Informant

Thomas B Hammaros.

Address 602 Deerfield Ave. Silver Spring.

17. Burial

Date thereof April 24-1941.

(Burial, cremation, or removal, which?)

(month) (day) (year)

Cemetery or cemetery

Location Lot 301, a a Co. met.

18. Funeral director Warren E Humphrey.

Address 8 1/2 Ga Ave. Silver Spring.

19. Date rec'd by registrar

Apr. 23

1941

Josephine M. Schaeffer

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County MONTGOMERY

City or town SILVER SPRING

(If outside city or town limits, write RURAL and give nearest town)

Street No. 602 DEERFIELD AVE.

(If rural, give LOCATION)

2. (a) If veteran, name war

None

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 21

1941 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

my Med. Center

and that I last saw h alive on

Immediate cause of death

coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

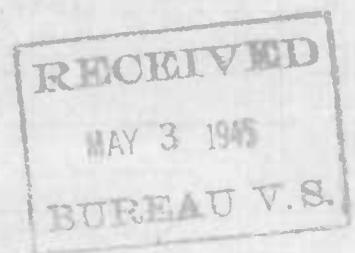
Injured at work?

23. SIGNATURE

Frank J. Broachard M.D.

Dep Med. Exam M. D. or other

Address Southbury Rd Date signed 4-21-41



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 181

## CERTIFICATE OF DEATH

04061 216  
Reg. Dist. No.

1. PLACE OF DEATH: Montgomery  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
Bethesda  
20 hours  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
USNH Bethesda, Maryland  
20 hours  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

D.C.  
State..... County.....  
Washington, D. C.  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 109 5th Street, S. E.  
(If rural, give LOCATION) ✓  
2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Leon Chester HARDIN, Sl/c V-6 USNR

## 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced  
Male White Married  
6.(b) Name of husband or wife..... Mrs. Rose Hardin  
7. Birth date of deceased (mo. day. yr.) 19 Dec. 1919  
6.(c) If alive, give age..... years  
8. AGE: Years Months Days If less than one day  
25 4 10 hrs. min.  
9. Birthplace..... Oklahoma  
(Town, county, and state)  
10. Usual occupation..... Navy  
11. Industry or business  
12. Name..... John Hardin  
13. Birthplace..... Tex ?  
14. Maiden name..... Edna Hardin (maiden name unknown)  
15. Birthplace..... Ark.  
16. Informant: wife: Mrs. Rose Hardin  
Address 109 5th St., S. E., Wash., D.C.  
17. removal Date thereof April 30, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory.....  
Location..... Dumas, Texas  
18. Funeral director..... W. W. Chambers, R.E.T.  
Address 1400 Chapin Street, N.W.

19. April 30, 1945  
(Date rec'd by registrar) Mary Charlotte Smith  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 29, 1945, at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from  
Self past, etc., 19, to 19  
and that I last saw h..... alive on 19  
Immediate cause of death.....

Shock  
Due to multiple burns of  
face body & extremities  
(several)  
Red clothing became ignited  
Other conditions from lighted cigarette  
DURATION 17 hours

(Include pregnancy within 8 months of death)

## Major findings of operations.....

Date of op.

## Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

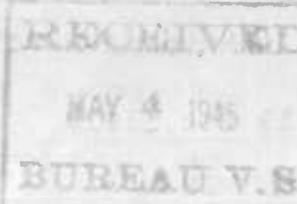
## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accidental Date of 4-29-45  
Where did injury occur? Wash. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) homeMeans of injury Burns Injured at work? No

## 23. SIGNATURE

Frank J. Brochard M.D.  
2100 16th Street, N.W. M.D. or other  
Address 4416 16th Street, N.W. Date signed 4-30-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46B

04062

Reg. Dist. No. 223

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County Maryland  
City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Washington Sanitarium and HospitalHow long in hospital or institution? 1 day

## 3. (a) FULL NAME

James, Mrs. Jessie Brown4. Sex F 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife Neal ✓ W. M. M. A.7. Birth date of deceased (mo., day, yr.) Oct. 2, 1871 8. (c) If alive, give age 73 years8. AGE: Years 73 Months 5 Days 22 If less than one day hrs. min.9. Birthplace Le Roy, Illinois (Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name John Taylor Phulman13. Birthplace Hager's Ferry, W. Va.14. Maiden name Cornelia Strider Engle15. Birthplace Hager's Ferry, W. Va.16. Informant Washington Sanitarium & HospitalAddress Takoma Park, Maryland17. Burial Burial Date thereof April 27, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Harden CemeteryLocation Hampden, Ohio18. Funeral director Arthur WallaceAddress 25 Carroll St., Takoma Park, D.C.19. Date rec'd by registrar April 25, 1945 Registrar J. H. D.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County P. C. I. C. R. S. C. A. C. R.City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1216 Montgomery Ave., Apt. 101  
(If Rural, give LOCATION)2. (a) If veteran, name war —

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 24, 1945 at 8:45 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 22 1945 to April 24 1945 and that I last saw her alive on April 24 1945

Immediate cause of death

Obstructive jaundice DURATION 10 wks.Due to Treatable malignancy ?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. —Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

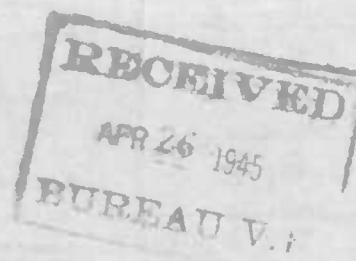
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) — (County) — (State) —Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work —

## 23. SIGNATURE

M. D. or other

Address Dr. J. H. McNeill, M.D. Date signed April 26, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1204

04063

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County... Montgomery

City or town... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... one month &amp; 5 days

Hospital, institution, or street address where death occurred:

U. S. NAVAL HOSPITAL, Bethesda, Md.

How long in hospital or institution?... one month &amp; five days

## 3. (a) FULL NAME

JOYCE, Edward Francis, AM2c USNR

## 3. (b) Social Security Number

4. Sex male	5. Color or race W-US	6.(a) Single, married, widowed, or divorced single
----------------	--------------------------	---

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of  
deceased (mo., day, yr.) 27 April 19228. AGE: Years 22 Months 11 Days 29 If less than one day  
hrs. .... min.9. Birthplace... Boston, Mass.  
(Town, county, and state)

10. Usual occupation... Navy

11. Industry or business... Navy

12. Name... Peter Joyce

13. Birthplace... Mass.

14. Maiden name... Mary Grant

15. Birthplace... Mass.

16. Informant... Mother: Mrs. Mary Joyce

Address 10 Elgin St., West Roxbury, Mass.

17. removal Date thereof... 4-26-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... New Calvary Cemetery

Location... Forrest Hills, Boston, Mass.

18. Funeral director... W. W. CHAMBERS, (N.C.S.B.)

Address 1400 Chapin St., N. W., Wash., D.C.

26 April 45  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Mass. County...

City or town... Boston  
(If outside city or town limits, write RURAL and give nearest town)

Street No... 10 Elgin St., West Roxbury

(If rural, give LOCATION)

2.(a) If veteran, name war... ✓

## MEDICAL CERTIFICATION

20. DATE OF DEATH... 26 APRIL 1945 at 950 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

21 MARCH 1945 to 26 APRIL 1945

and that I last saw h. i.m. alive on 26 APRIL 1945

Immediate cause of death...

CARDIOVASCULAR COLLAPSE DURATION 4 Hours

Due to... PARALYTIC ILEUS DURATION 1 WEEK

Due to... ULCERATING COLITIS PROCTIS DURATION 54 days

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury...

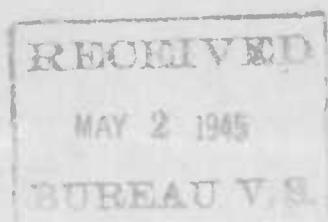
Injured at work?

23. SIGNATURE... Alvin B. Hayes

M. D. or other

Address... 1000 Haslett Rd., Washington, D.C.

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04664

223

Reg. Dist. No.

## 1. PLACE OF DEATH:

County

Montgomery

City or town

Towson Park Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred

805 Maple St.

How long in hospital or institution?

## 3. (a) FULL NAME

Bertha S. Kegel

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Feb. 29, 1852

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Feb. 29, 1852

8. AGE:

93

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Rochester New York

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name

Joseph H. Crane

13. Birthplace

Unknown

14. Maiden name

Charity Hinans

15. Birthplace

H. Kenneth Kegel - Son

16. Informant

Removal

Date thereof

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

S. H. Kegel Co.

18. Funeral director

2901-14 S. H. Kegel

Address

19. April 9

1945

J.W. Dudley

Registrar

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

District of Columbia

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3825 Morrison St.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Apr. 9

1945 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 4

1945 to

Apr. 9, 1945

and that I last saw her alive on

Apr. 9,

1945

immediate cause of death

Arterios - sclerotic

DURATION

Inert

Due to congestive heart failure

Due to

1 day

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

J. S. Kegel, M.D.

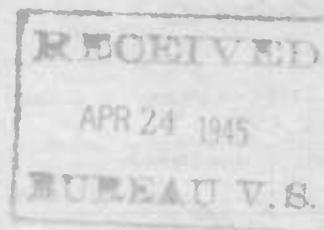
M. D. or other

Address 6911 5th &amp; New

Date signed 4/9/45

RELATED TO THE INVESTIGATIVE ACTIVITIES OF THE

Mr. Bertha Kugel



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 112

04065

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Cherry Chase  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Emma Welch Kitchum

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife

George Kitchum

7. Birth date of deceased (mo., day, yr.)

Dec. 16, 1869

8. (c) If alive, give age years

8. AGE: Years 76 Months  Days  If less than one day  
 hrs.  min.

9. Birthplace Siatt Co. Ill  
 (Town, county, and state)10. Usual occupation Housewife11. Industry or business 12. Name David C. Welch13. Birthplace Ill14. Maiden name Clemintine Robinson15. Birthplace Ind16. Informant Marian KitchumAddress 6710 Central ave.17. Burial Date thereof 8/29/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. George - GaLocation The St. Hines Co.18. Funeral director The St. Hines Co.Address 2901 - 14th St. NW19. 4/29 19 45 7pm E. Jones

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Montgomery  
 City or town Cherry Chase  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6710 Central ave  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 19 45 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 25 19 45 to April 28 19 45  
 and that I last saw her alive on April 28 19 45

Immediate cause of death

Acute Heart Failure DURATION 1 dayDue to AsthmaDue to Other conditions Infected toothextraction 3 day (Include pregnancy within 3 months of death)

Major findings of operations

Date of op. 

Autopsy results

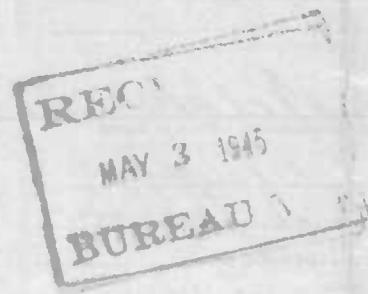
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of Where did injury occur?  (City or town)  (County)  (State)

Injured at home, farm, industry, public place (where?)

Means of injury  Injured at work? 23. SIGNATURE Gilbert B. Rude M.D. M. D. or otherAddress 3900 Military rd Date signed 4/29/45



PLEASE WRITE PLAINLY, WITH UNADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

04066

## CERTIFICATE OF DEATH

Reg. Dist. No.

214

## 1. PLACE OF DEATH:

County

Montgomery Co

City or town

Silver Spring Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Three months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Anna Longo

4. Sex

Fe

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Anthony Longo

7. Birth date of deceased (mo., day, yr.)

Feby 13, 1882

6. (b) If alive, give age years

8. AGE:

Years  
63Months  
2Days  
10If less than one day  
— hrs. — min.

## 9. Birthplace

Italy, close to Naples

(Town, county, and state)

## 10. Usual occupation

in Housewife

## 11. Industry or business

12. Name

Unknown

13. Birthplace

14. Maiden name

Anna Bello

15. Birthplace

Russia

16. Informant

John Longo

Address

1338 Red Tail Lane NW

17. (Burial, cremation, or removal. Which?)

Burial Date thereof Apr 24 1945

(month) (day) (year)

Cemetery or crematory

Mt. Calvary

Location

Longfellow Park

18. Funeral director

Jos. Paulsen Son

Address

1756 P. A. NW. DC.

19. (Date rec'd by registrar)

19.

Apr 23 1945 Josephine M. Schaeffer

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Montgomery

City or town

Silver Spring (Rural)

Street No.

(Rural) "White Oak"

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Apr. 23

19.

45 at 5:45 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Apr 23

19.

45 to

Apr 23 1945

and that I last saw her alive on

Apr 23 1945

19.

Immediate cause of death

Coronary Disease  
of heart

12 months

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John N. Andrews MD

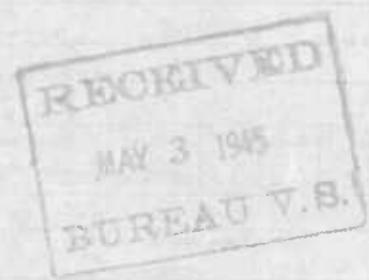
M. D. or other

Address

1960 Colesville Rd

Date signed

Apr 23 1945



M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04067

## CERTIFICATE OF DEATH

Reg. Date No. 214

1. PLACE OF DEATH: 8712 - Colesville Road  
 County: Montgomery  
 City or town: Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? -  
 Hospital, Institution, or street address where death occurred: -  
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State: Maryland County: Montgomery  
 City or town: Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No: 8712 - Colesville Rd. # 308  
 (If rural, give LOCATION)

2.(a) If veteran, name war: -

## 3. (a) FULL NAME

MARIE LESLIE

## 3. (b) Social Security Number

4. Sex: Female	5. Color or race: White	6. (a) Single, married, widowed, or divorced: Married
6. (b) Name of husband or wife: Cornelius R. Syle		6. (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): June 12, 1884		8. AGE: Years: 60 Months: 10 Days: 12 If less than one day: - hrs: - min: -
9. Birthplace: New York City, New York (Town, county, and state)		
10. Usual occupation: Housewife		
11. Industry or business: -		
12. Name: Frederick Brower		
13. Birthplace: New Jersey		
14. Maiden name: Marie M. Steenken		
15. Birthplace: Unknown		
16. Informant: Cornelius R. Syle		
Address: 8712 - Colesville Road, Silver Spring		
17. Burial, cremation, or removal: Burial Removal Date thereof: April 24, 1945 Cemetery or crematory: Cedar Hill Cemetery Location: Washington, D.C.		
18. Funeral director: Martin W. Hysong Co.		
Address: 1300 - N. St. N.W., Wash. 15, D.C.		

19. Apr. 24, 1945 Josephine M. Schaeffer  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

2D. DATE OF DEATH: APRIL 24, 1945, at 3:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1941 to April 1945 and that I last saw her alive on April 23, 1945.

Immediate cause of death: Cardiac failure, 1 day

Due to: Hyperperfusion - Cardiogenic  
 and/or Pulmonary Disease

Due to: Hemiplegia, 6 days

Other conditions: Urinary tract infection, 2 days  
 (Include pregnancy within 3 months of death)

Major findings of operations: - Date of op.:

Autopsy results: -  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of:

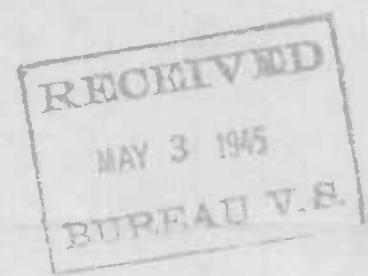
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: - Injured at work?

23. SIGNATURE: J. B. Glenn M. D. or other

Address: 2015 Chestnut St. Date signed: 4-24-45



PLEASE WRITE PLAINLY, WITH **NON-FADING INK**. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 460 ✓

04068

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County... Montgomery

City or town... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... four months, 17 days

Hospital, Institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution?... four months, 17 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Nebr.

County...

Omaha

City or town...

(If outside city or town limits, write RURAL and give nearest town)

Street No... 2303 South Taw St.,

(If rural, give LOCATION)

2.(a) If veteran, name war... ✓

## 3.(a) FULL NAME

LYNCH, George Francis, Captain USMCR

## 3.(b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

7-US

single

6.(b) Name of husband or wife...

6.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.)

22 July 1918

8. AGE: Years

Months

Days

If less than one day

26

8

19

hrs.

min.

9. Birthplace... Nebr.

(Town, county, and state)

10. Usual occupation... Marine Corps

11. Industry or business

12. Name... William P. Lynch

13. Birthplace... Neb.

14. Maiden name... Mary Rauber

15. Birthplace... Neb.

16. Informant... Mother: Mrs. Mary Lynch

Address 2303 South Taw St., Omaha, Neb.

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof... 4-2-45

(month) (day) (year)

Cemetery or crematory...

Location... Omaha, Neb.

18. Funeral director... W. C. Chambers

Address 1400 Chapin St., N. W., Wash., D.C.

19. April 2 1945 Mary Charlotte Smith

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... April 1 1945 at 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

14 November 1944 to April 1 1945

and that I last saw h... in alive on 31 March 1945

Immediate cause of death...

adenocarcinoma of Stomach.

DURATION

Aug. 1944

Due to...

Due to...

Other conditions...

ascites

(Include pregnancy within 8 months of death)

Major findings of operation... advanced carcinoma of stomach with ascites Date of op. Dec. 4, 1944

Autopsy results...

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

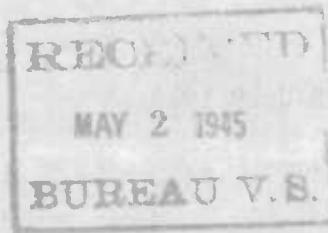
Means of injury Injured at work?

23. SIGNATURE...

Michael Reddish S. (M) USNR

M. D. or other

Address N.N.M.C. Bethesda, Md. Date signed...



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04069

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County: Mount

City or town: Rockville Pike

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 1/2 months

Hospital, institution, or street address where death occurred:

Waverly Sanatorium

How long in hospital or institution?

## 3. (a) FULL NAME

Anna M. Macsherry

## 3. (b) Social Security Number

## 4. Sex

Female white widowed

## 5. Color or race

## 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife: Dr. Clinton W.

7. Birth date of deceased (mo., day, yr.) Feb. 13 1859

## 6.(c) If alive, give age years

8. AGE: Years 86 Months Days If less than one day hrs. min.

9. Birthplace: Reading Pa. (Town, county, and state)

10. Usual occupation.

11. Industry or business

12. Name: Frank M. Heester

13. Birthplace: Pa.

14. Maiden name: Ella Lauman

15. Birthplace: Pa.

16. Informant: E. H. Hoogewerf.

Address: Some

17. Cremation Date thereof: 4/9/45  
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory: Cedar Woods Cem.

Location: Maryland

18. Funeral director: C. W. Reckers Humphrey

Address: 7557 W. Ave. Beebe, Md.

19. 4/9 1945 Wm E. J. P. M. Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md.

County: Mount

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8th 1945 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 15th 1945 to April 8th 1945 and that I last saw her alive on Apr. 8th 1945.

## Immediate cause of death

Cerebral hemorrhage Six days

## DURATION

Arterial hypertension 5 years

Due to Arterio-sclerosis 8 to 10 years

Due to

Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

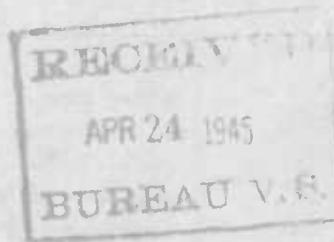
Means of injury

Injured at work?

23. SIGNATURE: Wheeler D. Huff M. D. or other

Address: Bethesda, Md. Date signed: Apr. 9/45

VS A15



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8370

T  
04070

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:  
County Montgomery Co.  
City or town Takoma-Pk.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, institution, or street address where death occurred:  
805 Maple Ave Takoma Park

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State D.C. County Washington  
City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 1217 Gallatin St. N.W.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## 3. (a) FULL NAME

Mary C. Martin

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced		
Female	White	Widow		
6.(b) Name of husband or wife: Richard C. Martin				
7. Birth date of deceased (mo. day, yr.)		8. (c) If alive, give age years		
Jan-4		Jan-4 - 1886		
8. AGE: Years		Months	Days	If less than one day
89				hrs. min.
9. Birthplace: Va.			(Town, county, and state)	
10. Usual occupation: H.W.				
11. Industry or business				
12. Name: John M. Kemper				
13. Birthplace: Va.				
14. Maiden name: Adeline Cole				
15. Birthplace: Va.				
16. Informant: Lora Martin				

Address 1217 Gallatin St. N.W.

17. Date thereof: 4-28-45  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Washington D.C.

Location 4812 - Gov. St. D.C.

18. Funeral director: Seal Funeral Home

Address 4812 - Gov. St. N.W. Wash. D.C.

19. April 28 1945 J.W. Miller  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April-28-45 19 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 24 1945 to Apr. 28, 1945, and that I last saw h. 5 alive on Apr. 27, 1945.

## Immediate cause of death

General hemorrhage 6 days.

Due to arterio-sclerotic conditions

Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

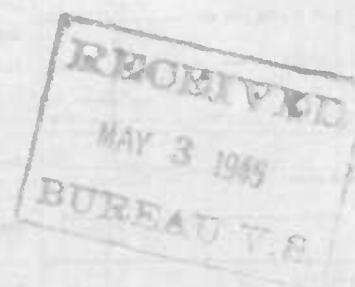
Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

M. D. or other  
5th & Cedar Sts  
Address Date signed Apr. 28/45



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4625

04671

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County... Montgomery

City or town... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... 4 months and 4 days

Hospital, institution, or street address where death occurred:

U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution?... 4 months &amp; 4 days

## 3. (a) FULL NAME

MASON, Mary L.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	W-US	widowed

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 15 June 1870

6. (c) If alive, give age... years

8. AGE: Years	Months	Days	If less than one day
74	9	26	hrs. min.

9. Birthplace... Conn.  
(Town, county, and state)

10. Usual occupation

## 11. Industry or business

12. Name... John Shea

13. Birthplace... Mass.

14. Maiden name... Johanna Shea (maiden name unknown)

15. Birthplace... Mass.

16. Informant... son: Captain Robert E. MASON USN

Address 3000 39th St., N.W., Wash., D.C.

17. removal Date thereof... 4-10-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... St. Bernard

Location... New Haven, Conn.

18. Funeral director... Joseph Gawler, &amp; Sons

Address 1750 Penn. Avenue, N.W., Wash., D.C.

19. 10 April 1945 Mary Charlotte Smith  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... County... Washington, D. C.

City or town... (If outside city or town limits, write RURAL and give nearest town)

Street No. 3000 39th St., N.W.

(If rural, give LOCATION)

2. (a) If veteran, name war... ✓

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH... April 10 1945 at 0400 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6 December 1944, to April 10 1945

and that I last saw her alive on April 10 1945

Immediate cause of death... Malnutrition

as end result of anorexia  
and bowel / intestinal  
obstruction

Due to... Cancer of the bowel. Duration 8 to 9 months

Due to... Cancer of the bowel. Duration 8 to 9 months

Other conditions... Severe Secondary Anemia

(Include pregnancy within 3 months of death)

Major findings of operations... None

Date of op.

Autopsy results... none performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur?... (City or town) (County) (State)

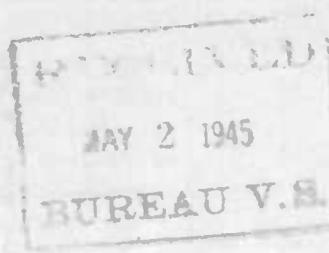
Injured at home, farm, industry, public place (where?)

Means of injury... Injured at work?

23. SIGNATURE... Gordon R. Sawyer

M. D. or other

Address... Natl. Mar. Med. Center Date signed 4-10-45



M

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH ~~CONFADING~~ INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *B10*

04072

218

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Montg. Co.,  
 City or town..... Gaithersburg, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 4 yrs 3 mo.

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Maud Arnold McDonald

## 3. (b) Social Security Number

4. Sex      5. Color or race      6. (a) Single, married, widowed, or divorced  
 Female      White      Madow

6. (b) Name of husband or wife..... William B McDonald

7. Birth date of deceased (mo., day, yr.)..... July 18th 1876

8. AGE:      Years      Months      Days      If less than one day  
 1876      68      9      11      hrs.      min.

9. Birthplace..... Baltimore Md.

(Town, county, and state)

10. Usual occupation..... House Wife,

## 11. Industry or business

12. Name..... John W Arnold

13. Birthplace..... Md

14. Maiden name..... Emma C. Stansbury

15. Birthplace..... Md

16. Informant..... Methodist Home H M Wilson

Address..... Gaithersburg Md,

17. Burial..... 5/2/45

(Burial, cremation, or removal. Which?)      Date thereof..... (month) (day) (year)

Cemetery or crematory..... Loudon Park Cemetery

Location..... Baltimore Md,

18. Funeral director..... Ernest C Gartner

Address..... Gaithersburg Md,

19. *April 30* 1945 Claude G Cooks  
 (Date rec'd by registrar)      Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland      County..... Montg.  
 City or town..... Gaithersburg Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 29th 1945 at 6 Pm.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1945 to April 29 1945  
 and that I last saw her alive on April 29 1945

Immediate cause of death.....

*Chronic glomerular nephritis*      Duration..... 3 years

Due to..... *Arteriosclerosis*

Due to.....

Other conditions.....

*Hypertension*  
*Arthritic arthritis*

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

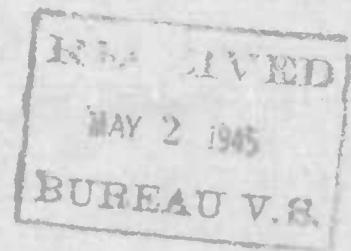
Where did injury occur?..... (City or town)      (County)      (State)

Injured at home, farm, Industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE..... *Gartner F. Neuber M.D.* M. D. or otherAddress..... Rockville, Md. Date signed *4/30/45*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *MD*

## CERTIFICATE OF DEATH

040-73 216  
Reg. Dist. No.

1. PLACE OF DEATH:  
County..... Montgomery  
City or town..... Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... nine months & 6 days  
Hospital, Institution, or street address where death occurred:  
U. S. Naval Hospital, Bethesda, Md.  
How long in hospital or institution?..... nine months & 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Tenn. County.....  
City or town..... Nashville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2618 Gallatin Road  
(If rural, give LOCATION) ✓

2.(a) If veteran, name war.....

## 3.(a) FULL NAME

MORGAN, Henrietta

## 3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife.....  
7. Birth date of deceased (mo., day, yr.)..... 22 March 1917  
6.(c) If alive, give age..... years

8. AGE: Years Months Days If less than one day  
28 1 4 ..... hrs. ..... min.

9. Birthplace..... Tenn.  
(Town, county, and state)

10. Usual occupation..... Navy

11. Industry or business..... Navy

12. Name.....	Litton Hickman
13. Birthplace	Tenn.

14. Maiden name.....	Henrietta Hill
15. Birthplace	Tenn.

16. Informant..... No: Mrs. Henrietta Hickman  
Address 2618 Gallatin Road, Nashville, Tenn.

17. removal Date thereof..... 4-26-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory..... Mt. Olivet

Location..... Nashville, Tenn.

18. Funeral director..... W. W. Chambers *RS*  
Address 1400 Chapin St., N.W., Wash., D.C.

19. 4-26-45  
(Date rec'd by registrar) 19..... *mary charlotte morgan*  
Registrar *Edward S. Hickman*

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 26 April 1945, at 8:21 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
4-26 1945, to 4-26 1945  
and that I last saw her alive on 4-26-45.

Immediate cause of death.....

*adenocarcinoma of sigmoid*  
Duration 5 hrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

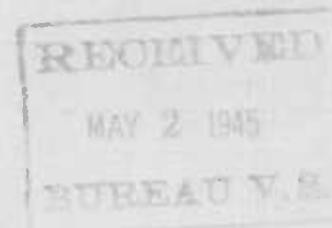
Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

*Edward S. Hickman*  
M. D. or other  
Address: U.S.N.H. Bethesda, Md. Date signed: 4-26-45



MARGIN BESEPVED FOR BINDING

15

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *129*

## CERTIFICATE OF DEATH

04074  
Reg. Dist. No. 216

1. PLACE OF DEATH: County..... City or town.....			
Montgomery Bethesda (rural)			
(If outside city or town limits, write RURAL and give nearest town)			
How long in above place of death?..... 4 days			
Hospital, Institution, or street address where death occurred: U. S. NAVAL Hospital, Bethesda, Md.			
How long in hospital or institution?..... 4 days			
3. (a) FULL NAME MOORE, Lucille Darlene			
4. Sex female	5. Color or race colored	6. (a) Single, married, widowed, or divorced married	
6. (b) Name of husband or wife..... Charles Henry Moore			
7. Birth date of deceased (mo., day, yr.)..... 22 November 1923			
6. (c) If alive, give age..... year			
8. AGE: Years 21	Months 6	Days 19	If less than one day ..... hrs. ..... min.
9. Birthplace..... Washington, D. C. (Town, county, and state)			
10. Usual occupation..... housewife			
11. Industry or business			
MOTHER FATHER	12. Name..... George McCorkle		
	13. Birthplace..... N.C.		
	14. Maiden name..... Hazel McCorkle (maiden name unknown)		
	15. Birthplace..... N.C.		
16. Informant: Mo: Mrs. Hazel McCorkle			
Address..... 3015 Georgia Avenue, N. W., Wash., D.C.			
17. burial (Burial, cremation, or removal. Which?)		Date thereof..... (month) (day) (year) 14 April 1945	
Cemetery or crematory..... Arlington National Cemetery Location..... Arlington, Va.			
18. Funeral director..... Jarvis, W. Ernest <i>J.W.</i>			
Address..... 1432 U St N. W., Wash. D.C.			
19. 4-11-45 (Date rec'd by registrar)		19.....	Mary Charlotte Smith Registrant

<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother)			
State.....	County.....		
City or town.....	Washington, D. C.		
(If outside city or town limits, write RURAL and give nearest town)			
Street No.....	3015 Georgia Avenue, N. W.		
(If rural, give LOCATION)			
2.(a) If veteran, name war.....	✓		
<b>3. (b) Social Security Number</b>			
<b>MEDICAL CERTIFICATION</b>			
20. DATE OF DEATH	April 10	19 15	at 10:25 E
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from			
6 April	19 15	to 10 April	19 15
and that I last saw h.....er alive on	10 April	19 15	
Immediate cause of death.....	Septicemia (Streptococcus)		
Due to.....	Pneumonia		
Due to.....			
Other conditions.....			
(Include pregnancy within 3 months of death)			
wn) Major findings of operations.....			
Date of op. ....			
Antopsy results.....			
PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following:			
Accident, suicide, or homicide.....		Date of.....	
Where did injury occur? .....		(City or town).....	(County).....
Injured at home, farm, industry, public place (where?) .....		(State).....	
Means of Injury.....		Injured at work?	
<u>A. W. Robishaw.</u>		R. W. ROBISHAW, Lt. Comdr. (MC) USNR	
23. SIGNATURE		M. D. or other	
Address.....		Date signed.....	

RECEIVED  
MAY 2 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

04075

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County..... Montgomery  
 City or town..... Fairland  
 (If outside city or town limits, write RURAL and give nearest town)  
 From March 23, 1945  
 Hospital, Institution, or street address where death occurred:  
 Cedarcroft Sanitarium  
 From March 23, 1945  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Montgomery  
 City or town..... Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1714 Corwin Drive  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... none

## 3. (a) FULL NAME

EMELIA FREDERIKA NELSON

## 3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife..... Alfred Nelson  
 7. Birth date of deceased (mo., day, yr.) July 14, 1866  
 6.(c) If alive, give age ..... years

8. AGE: Years	Months	Days	If less than one day
78	8	19	..... hrs. ..... min.

9. Birthplace..... Sweden  
 (Town, county, and state)

10. Usual occupation..... housewife

11. Industry or business.....

12. Name.....	Carl Person
13. Birthplace.....	Sweden

14. Maiden name.....	unknown	STINA MARIA SVENSEN
15. Birthplace.....	Sweden	

16. Informant.....	Dr. A. A. Nelson
Address	1714 Corwin Dr. Silver Spr.

17. removal	Date thereof.....	Apr 5 45	
(Burial, cremation, or removal. Which?)	(month)	(day)	(year)

Cemetery or crematory.....	ONEATA
----------------------------	--------

Location.....	DULUTH MINN. (St Louis Co.)
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18. Funeral director.....	Warren & Humphrey
Address	8434 Ga Ave - Silver Spring, Md.

19. Date rec'd by registrar	Apr 5 1945	Josephine M. Schell
Registrar		

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 3 1945, at 11:14 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23 1945, to April 3 1945

and that I last saw her alive on April 3 1945

Immediate cause of death..... Chronic Myocarditis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

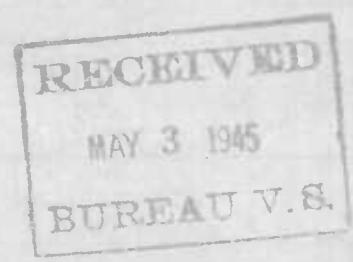
Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Cedarcroft Sanitarium

Date signed..... 4/3/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 750

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

04076

## 1. PLACE OF DEATH:

County Montg

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Carrie Newberger

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE: 80 Years Months Days If less than one day hrs. min.

9. Birthplace Baltimore Md

(Town, county, and state)

10. Usual occupation Retired

## 11. Industry or business

12. Name Samuel Newberger

13. Birthplace Germany

14. Maiden name Smith

15. Birthplace

16. Informant Mabel J Paul

Address 7832-16th St NW

17. Cremation Date thereof April 10 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Crematory

Location Sutherland Prince George Md

18. Funeral director B. Sangerly &amp; Son

Address 3501-14th St NW

19. April 19 Josephine M Schaeffer

(Date rec'd by registrar) 1945

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County Montg

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9508

Baltimore Dr

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 8 1945 at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dey Med. Esmer Case 19.

and that I last saw h alive on 19.

## Immediate cause of death

Acute Myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Brochard M.D.

Date signed 4-8-45 M. D. or other

Address 10th Street and Date signed 4-8-45

RECEIVED  
MAY 3 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

## CERTIFICATE OF DEATH

04077  
2/16  
Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

6803 Clarendon Road

How long in hospital or institution?.....

## 3. (a) FULL NAME

John J. Nock

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white Widowed  
Jannie L. Nock

6. (b) Name of husband or wife

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

June 13, 1861

8. AGE:

Years

Months

Days

If less than one day

831013

hrs.

min.

9. Birthplace

Virginia  
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Farmer

MOTHER

FATHER

12. Name John Nock13. Birthplace Virginia14. Maiden name Sarah Floyd15. Birthplace Virginia

16. Informant

Ellen Sarah FrederickAddress 6803 Clarendon Rd., Bethesda, Md.17. Burial place and date thereof. April 27, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory WachapreagueLocation Wachapreague, Va.18. Funeral director Warren G. HumphreyAddress Silver Spring, Md.19. 4/26 1945 9m 5 Jules  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6803 Clarendon Road  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 26 1945and that I last saw him alive on April 26 1945

Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to HypertensionDue to Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

23. SIGNATURE

E. A. D. D.M. D. MontgomeryAddress Bethesda Md. Date signed April 26 1945



M  
N. B.—WRITE PLAINLY, WITH UVYDING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH  
County Montgomery  
Village or City Cherry Chase  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

## 1. PLACE OF DEATH

County

Village or City

Length of residence in city or town where death occurred

Registration Dist. No. 216St. 11178 Ward 216

(If death occurred in a hospital or institution, give its NAME instead of street and number)

## 2. FULL NAME

(a) Residence: No.

1105 Oliver

St.

Ward.

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX F4. COLOR, OR RACE W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

widowed

5a. If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofMartin Nolan

6. DATE OF BIRTH (month, day, and year)

Oct 17, 1860

7. AGE

Years 84Months 5Days 20If LESS than  
1 day, \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.

## OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town)

(State or country)

Springfield, Va

## MOTHER FATHER

13. NAME Timothy Murphy

14. BIRTHPLACE (city or town)

(State or country)

Delaware15. MAIDEN NAME Elizabeth Kelly

16. BIRTHPLACE (city or town)

(State or country)

Ireland17. INFORMANT Mrs. J. L. Saunders

(Address)

1105 Oliver St. Cherry Chase

18. BURIAL, CREMATION, OR REMOVAL

641-H-2 E. Wash Dc

Place

Wash Dc

Date

Apr 7, 194519. UNDERTAKER Albert J. Nolan

(Address)

641-H-2 E. Wash Dc20. FILED 4/7, 1945

19

Wm E. Jobes

Registrar

T

926  
041178

216

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

Apr 771945

22. I HEREBY CERTIFY That I attended deceased from

Apr 26, 1944, to Apr 7, 1945I last saw her alive on Apr 5, 1945; death is saidto have occurred on the date stated above, at 7 A.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Chronic myocarditis  
Paroxysmal tachycardia  
Arteriosclerosis

Date of onset

Other Contributory Causes of importance:

None

Name of operation

None

Date of

What test confirmed diagnosis?

Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of injury , 19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

M. D.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

## Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gallstones	May 1, 1923

Other contributory causes of importance:

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04079

216

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

## 3. (a) FULL NAME

Lilly Ogletree

4. Sex

5. Color or race

F. W. Widowed.

6. (b) Name of husband or wife

George Ogletree

7. Birth date of deceased (mo., day, yr.)

Oct. 29, 1852.

6(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

92

5

23

hrs.

min.

9. Birthplace

New York, N.Y.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

Unknown

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

16. Informant

Mrs. Constance Swenson

Address

Cabin John, Md.

17. Removal

Date thereof

Apr. 23, 1945

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

W.W. Chambers Co.

Address

Wash. D.C.

19. 4/23 1945 212 E. Jobee

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Montgomery

City or town

Cabin John

Ward No.

Street No.

Riverside Ave.

(If rural give LOCATION)

## 2(a) IF VETERAN, NAME WAR

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 2D. DATE OF DEATH

April 22 1945, at 7:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1941 to April 1945  
and that I last saw her alive on April 20, 1945

Immediate cause of death: Coronary Artery Disease

DURATION

Due to

Due to

Dementia

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Lester Swenson, M.D.

M. D. or other

Address 8016 Langley Rd Date signed 4/27/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9<sup>th</sup>

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

04089

## 1. PLACE OF DEATH:

County

Montgomery  
Bethesda, Md.

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1 yr.

Hospital, Institution, or street address where death occurred:

117 West Glenbrook Rd.

How long in hospital or institution?

## 3. (a) FULL NAME

Nicholas Dorsey Offutt

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married  
Rennie Bohner

6. (b) Name of husband or wife

6. (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.)

Nov. 18, 1889

8. AGE:

Years  
57

Months

Days

If less than one day

hrs. min.

9. Birthplace

Rockville, Md

(Town, county, and state)

10. Usual occupation

Stock Room Clerk C.T. Co.

11. Industry or business

Nicholas Dorsey Offutt  
Jones Co. Md

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

Elizabeth Williams  
Fort George, Wash. Md.

16. Informant

Ellen R. Ferris

Address

Sister

17. Burial

Date thereof 4/25/45  
(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Rockville Union Cem

Location

Rockville, Md

18. Funeral director

Wm Reuben Humphrey

Address

7557 Wisconsin Ave. Bethesda

19. (Date rec'd by registrar)

4/24 1945

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md County

City or town

Bethesda, Md.

Street No.

117 West Glenbrook Rd.

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 24 1945 at 1945 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1945 to April 1945

and that I last saw h. in alive on April 24 1945

Immediate cause of death

Cerebral Thrombosis

Due to Hospitalized since Jan. 1945

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

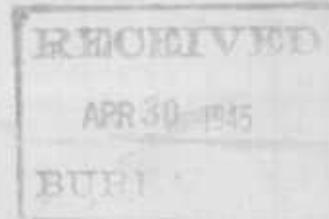
Means of injury

Injured at work?

23. SIGNATURE

R. S. Sonnenburg M. D. or other

Address 5016 Georgia St. Date signed 4/23/45



## MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
 CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state  
 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-  
 TION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

04081

## 1. PLACE OF DEATH

County Montgomery

Village or City Rockville

Length of residence in city or town where death occurred 3 yrs. 0 mos. 0 ds. How long in U.S. if of foreign birth? 0 yrs. 0 mos. 0 ds.

## 2. FULL NAME Mrs. Adelaide Ord

(a) Residence: No. Route #1, Alexandria, Va. (Usual place of abode)

No. 500 W. Montgomery Ave.

St. 213

Ward

If U.S. Veteran, specify WAR

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX F	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
----------	------------------------	---

5a. If married, widowed or divorced  
HUSBAND of (or) WIFE of

William D. Ord

## 6. DATE OF BIRTH (month, day, and year)

April 26-1864

7. AGE Years 80	Months 11	Days 16	If LESS than 1 day, hrs. or min.
-----------------	-----------	---------	----------------------------------

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.	Housewife
9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.	
10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town)  
(State or country)

Pennsylvania

Date of onset

4/11/45

Indefinite

13. NAME William Sharpe
-------------------------

14. BIRTHPLACE (city or town) (State or country)
---

15. MAIDEN NAME Unknown West
------------------------------

16. BIRTHPLACE (city or town) (State or country)
---

17. INFIRMANT Wm. D. Ord—II - nephew
--------------------------------------

(Address) 906-Endebby St. Alexandria, Va.

18. BURIAL, CREMATION, OR REMOVAL
-----------------------------------

Place Philadelphia, Pa. Date April 12, 1945

19. UNDERTAKER Wm. Leubel Humphrey
------------------------------------

(Address) Rockville, Maryland

20. FILED 4/11/45
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Registrar.

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

April 11, 1945

22. I HEREBY CERTIFY, That I attended deceased from March 14, 1942, to April 11, 1945.

I last saw her alive on April 11th, 1945; death is said to have occurred on the date stated above, at 7:05 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Thrombosis, cerebral	4/11/45
Arteriosclerosis, general	Indefinite
Arteriosclerosis, cerebral	1940

## Other Contributory Causes of importance:

Psychosis, cerebral arterio-sclerosis	1940
---------------------------------------	------

Fracture of hip	3/29/45
-----------------	---------

Name of operation	Due to an accidental fall
-------------------	---------------------------

What test confirmed diagnosis?	Was there an autopsy?
--------------------------------	-----------------------

23. If death was due to external causes (VIOLENCE) fill in also the following:
--

Accident, suicide, or homicide?	Accident
---------------------------------	----------

Where did injury occur?	Date of injury March 29, 1945
-------------------------	-------------------------------

(Specify city or town, county and State)	
--	--

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.	
---	--

Manner of injury	Accidental fall
------------------	-----------------

Nature of Injury	
------------------	--

24. Was disease or injury in any way related to occupation of deceased?
---

If so, specify
----------------

(Signed)	Douglas Noble
----------	---------------

(Address)	500 W. Montgomery Ave
-----------	-----------------------

M. D.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, c. g., heart failure, asphyxia, asthenia, etc. At principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis	Date of onset
	1915
Chronic interstitial nephritis	1921

Cerebral hemorrhage	July 5, 1927
---------------------	--------------

--	--

--	--

Other contributory causes of importance:	
--	--

Gallstones	May 1, 1928
------------	-------------

## Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	Date of onset
Run over by street car	1 week ago
Peritonitis	3 days ago

--	--

--	--

Other contributory causes of importance:	
--	--

Gastroenteritis	1 year
-----------------	--------

--	--

--	--

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04082

FILM NO. G 95 JUN 16 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:

County Maryland  
City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 4-10-45 @ 9:00 A.M. - 4/11/45

3. (a) FULL NAME

Mrs. Marie G. Levy  
4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) May 20 - 1875 8. (c) If alive, give age 70 years

8. AGE: Years 70 Months 69 Days 11 If less than one day hrs. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business —

12. Name Clarinda Goodman

13. Birthplace Virginia

14. Maiden name Hardy

15. Birthplace Virginia

16. Informant Mr. Stephen Johnson (Daughter)

Address 412 Sheppard St. Chevy Chase, Md.

17. Removal Date thereof. (month) (day) (year)

Cemetery or crematory

Location W.W. Chambers Co.

18. Funeral director W.W. Chambers Co.

Address 1400 Shapell St. N.W. D.C.

19. 4/11 1945 Date rec'd by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)  
Street No. Old Georgetown Road (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1945 at 5:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1945 to April 11 1945 and that I last saw her alive on April 11 1945

Immediate cause of death Perforating occlusion 9 myocardial infarction DURATION 24 hours

Due to atherosclerotic heart disease several years

Due to Hypertensive disease

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op. ....

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

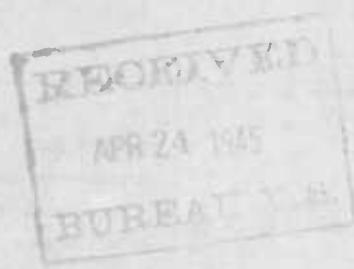
Means of injury .....

Injured at work? .....

23. SIGNATURE Edmund Murphy MD M. D. or other Stiegley

Address 1726 Eye St. N.W. Washington 6 Date signed 4/11/45

Address Washington 6 Date signed 4/11/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04083

## CERTIFICATE OF DEATH

Reg. Dist. No. 211

## 1. PLACE OF DEATH:

County..... Montgomery  
 City or town..... Damascus (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

William E. Pignette

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MaleWhiteMarried

B. (b) Name of husband or wife

Marie Bell Pignette6. (c) If alive, give age 27 years

7. Birth date of

deceased (mo., day, yr.)

January 8, 1908

8. AGE:

Years

Months

Days

If less than one day

41

3

2

hrs.

min.

9. Birthplace

Damascus, Montgomery

(Town, county, and state)

10. Usual occupation

MerchantStore

11. Industry or business

12. Name

Price Pignette

13. Birthplace

Baltimore County

14. Maiden name

Annie Dawson

15. Birthplace

Frederick County

18. Informant

Mrs. William E. Pignette

Address

Damascus, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof April 8, 1945

(month) (day) (year)

Cemetery or crematory

Methodist Church

Location

Damascus, Md.J. B. B. Hall, Inc.

18. Funeral director

Address

Damascus, Md.J. B. B. Hall, Inc.

19. Date rec'd by registrar

April 4, 1945

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... MontgomeryCity or town..... Damascus (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 8

1945, at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 8, 1945, to April 8, 1945, and that I last saw him alive on April 8, 1945.

Immediate cause of death Arteriosclerotic cardio-vascular disease with hypertrophy and dilatation of heart

DURATION

5 yearsDue to Marked dehiscence and bunching deformity of the whole body

35 years

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury

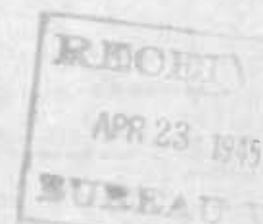
Injured at work?

23. SIGNATURE James P. Kerr M.D.

M. D. or other

Address..... Damascus, Md. Date signed 4/4/45

LETTER TO DEPARTMENT OF STATE, RULIHAM  
RECORDED AND INDEXED  
APR 23 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

04684

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 yrs.Hospital, Institutes, or street address where death occurred: Washington Sanitarium + HospitalHow long in hospital or institution? 6 mo.

## 3. (a) FULL NAME

Mrs. Flora F. Plummer4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Mr. Frank Plummer7. Deceased Deceased 8. (c) If alive, give age — years7. Birth date of deceased (mo., day, yr.) April 27-1862-8. AGE: Years 82 Months 11 Days 12 If less than one day hrs. 00 min. 009. Birthplace Jay Center - Indiana (Town, county, and state)10. Usual occupation Sabbath School Secretary cont. cont. of S.S. Secy.11. Industry or business Retired12. Name John H. Fair13. Birthplace Penna.14. Maiden name Elizabeth Catherine Hobart - Fair15. Birthplace Penna.16. Informant Washington San. RecordsAddress Takoma Park, Md.17. Burial Date thereof April 10, 1945. (month) (day) (year)Cemetery or crematory Fox Creek CemeteryLocation Washington, D.C.18. Funeral director J. Julian & TalbotAddress 254 Russell St. Takoma Park, D.C.19. Date rec'd by registrar April 9, 1945 J. H. HobartRegistrar J. Hobart

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Takoma Park (If outside city or town limits, write RURAL and give nearest town)Street No. 128 Willow St. (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1945 at 3:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sat 4 a.m. April 7 to 10 1945and that I last saw her alive on April 7 1945Immediate cause of death Coronary disease: general and cerebralDue to Left cerebral hemorrhage 3 amDue to Hypertension Two days

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John H. Hobart M.D. or otherAddress 502 Maryland St. D.C. Date signed 4-8-45

Washington, D.C.

RECEIVED  
APR 24 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16402

04085

## CERTIFICATE OF DEATH

Reg. Dist. No. 211

## 1. PLACE OF DEATH:

County

Montgomery

City or town

Cedar Grove P.D. Germantown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Four years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Elmores Nelson Rose

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Maudie V. Rose

7. Birth date of

deceased (mo., day, yr.)

Dec 25 - 1881

6. (c) If alive, give age 50 years

8. AGE:

Years

Months

Days

If less than one day

63

3

28

hrs.

min.

9. Birthplace

Montgomery Co. Md

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

Building

12. Name

Elmores V. Rose

13. Birthplace

Montgomery Co. Md

14. Maiden name

Maudie V. Rose

15. Birthplace

Montgomery Co. Md

16. Informant

Maudie V. Rose

Address

Germantown 2nd

17. Burial

Date thereof April 23 - 1945

(month) (day) (year)

(Burial, cremation, or removal, where?)

Baptist Cemetery

Locality

Montgomery Co. Md

18. Funeral director

Roy W. Barber

Address

Chestertown 1st

19. April 24, 1945

(Date rec'd by registrar)

Della N. Burdette

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Cedar Grove 1/12 Germantown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

212-14-5856

## MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 20

1945 a.m. 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept med. exam. case

19

and that I last saw h. alive on

19

Immediate cause of death

Hemorrhage

Due to gun shot wound  
Right heart (suicide)

DURATION

dead

instant

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

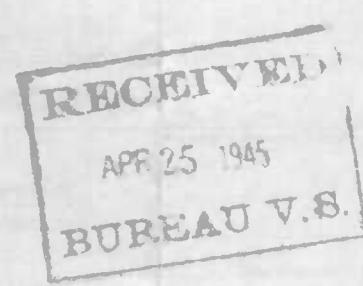
Accident, suicide, or homicide. suicide Date of 4-20-45Where did injury occur? Cedar Grove County Md State Md

Injured at home, farm, Industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frank J. Brochart M.D. M. D. or otherAddress Germantown 2nd Date signed 4-20-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2561

04086

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

2 days

## 3. (a) FULL NAME

Christian F. Rasmussen

4. Sex

m

5. Color or race

w

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Minnie K. Rasmussen

7. Birth date of deceased (mo., day, yr.)

September 25, 1879

6. (c) If alive, give age years

8. AGE: Years 65 Months 6 Days 15 If less than one day  
 hrs. ..... min. ....

9. Birthplace Denmark  
 (Town, county, and state)10. Usual occupation Sail maker11. Industry or business Dairy Yard12. Name Martin P. Rasmussen13. Birthplace Denmark14. Maiden name Aileen ?15. Birthplace Denmark16. Informant Hospital RecordsAddress Suburban Hospital17. Cremation Date thereof 4/11/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar Hill Cem.Location Maryland18. Funeral director Wm. F. RasmussenAddress 7557 W. Ave. Bethesda19. 4/11 19 45 NE. 10th St. Md.

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington County DCCity or town U.S. (If outside city or town limits, write RURAL and give nearest town)

Street No. .... (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4/9 1945 at 11:27 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/16 1945 to 4/9 1945 and that I last saw h. alive on 4/9 1945

Immediate cause of death

Paralysis fromDue to Paralysis due to central hemisph.

Due to

Other conditions Hypertension

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

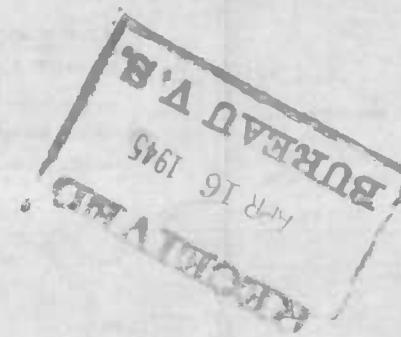
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of Injury Injured at work?23. SIGNATURE Brace Benjamin M.D.

M. D. or other

Address Bethesda, Md. Date signed 4/9/45



M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04687

83-P

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County..... Montgomery  
City or town..... Fairland

(If outside city or town limits, write RURAL and give nearest town)

from March 1, 1945

## Hospital, institution, or street address where death occurred:

Cedarcroft Sanitarium

## How long in hospital or institution? from March 1, 1945

## 3. (a) FULL NAME

JULIA KEMLER (SWARTZ) REESER

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced  
widowed

6.(b) Name of husband or wife..... Frederick H. Reeser

7. Birth date of deceased (mo., day, yr.) February 23, 1872 6.(c) If alive, give age..... years

8. AGE: Years 73 Months 2 Days 6 If less than one day  
hrs. ..... min.

9. Birthplace..... Missouri, near St. Louis  
(Town, county, and state)

10. Usual occupation..... housewife

## 11. Industry or business

12. Name..... Jacob J. Swartz

13. Birthplace..... Platteville Wisconsin

14. Maiden name..... Helen Meier

15. Birthplace..... Platteville Wisconsin

16. Informant..... Miss Alice Swartz

Address..... 215 Emerson St. N.W. Wash.D.C.

17. Cremation..... Date thereof..... May 1st 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Nat. Cemetery -

Location..... Dr. L. S. Co. Md.

18. Funeral director..... The S.H. Finch Co.

Address..... 2901-14th St. NW.

19. Date rec'd by registrar..... Apr. 29 1945

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Dist. of Col. County.....

City or town..... Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 215 Emerson St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 29

19 45 at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1 -

1945 to April 29 1945

and that I last saw her alive on April 29 - 1945

## Immediate cause of death

Cerebral Thrombosis

DURATION

2 days

## Due to

## Due to

## Other conditions

General Arteriosclerosis

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

23. SIGNATURE..... Richard B. Hibadean M.D.

M. D. or other

Address..... Cedarcroft Sanitarium Date signed..... Apr. 29 1945

Registrar

RECEIVED

MAY 3 1945

BUREAU V.F.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

04088

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County

City or town

Montgomery  
Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

45 hours

## 3. (a) FULL NAME

Mrs. Almira Richardson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white, married  
L. S. Richardson

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Aug. 3, 1894

8. AGE:

Years

Months

Days

If less than one day

50

8

22

hrs.

min.

9. Birthplace

New York

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Arthur H. Carpenter

MOTHER

FATHER

12. Name

New York State

13. Birthplace

Anna J. Plunket

14. Maiden name

Canada

15. Birthplace

S. S. Richardson

16. Informant

1610 Pickwick Lane

Address

Removal

Date thereof 4/25/45  
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

S. H. Jones Co

18. Funeral director

1901 - 14th St. N.W. Wash. D.C.

Address

4/25 1945 7pm E. Jones

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County Montgomery

City or town Cherry Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1610 Pickwick Lane

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 1945, at 5:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/23/45 to 4/25 1945 and that I last saw her alive on 4/23/45.

Immediate cause of death

Cerebral Occlusion

Due to Cerebral Haemorrhage 3 days

Due to Hypotension

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. G. Martinez

M. D. or other

Address Date signed



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186a

04089

## CERTIFICATE OF DEATH

Reg. Dist. No. 213

## 1. PLACE OF DEATH:

County

Montgomery  
Sleepy - R & D #2 Rockville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

21 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color of race

6. (a) Single, married, widowed, or divorced

female White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day, yr.) June 5-1870

6. (c) If alive, give age years

8. AGE: Years Months Days It less than one day  
74 10 6 hrs. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation Sleepy keeper

## 11. Industry or business

12. Name Robert H. Rickells

13. Birthplace Maryland

14. Maiden name Mary E. Nicholson

15. Birthplace Maryland

16. Informant Mrs. Mary H. Burroughs

Address R &amp; D #2 Rockville - Maryland

17. Burial Date thereof April 14/45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Rockville Union Cemetery

Location near Rockville - Maryland

18. Funeral director Tom Rubin Funeral Director

Address Rockville - Maryland

19. 4/13 (Date rec'd by registrar) 155 Josephine &amp; Hall

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Montgomery

City or town Sleepy - R &amp; D #2 Rockville

(Outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 11

1945 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 24 1945 to April 11 1945

and that I last saw her alive on April 11 1945

Immediate cause of death

Cerebral hemorrhage

DURATION

12 hrs.

Due to

Due to

Other conditions Fracture right femur 2 1/2 mo.

Due to: Accidental fall. (Include pregnancy within 8 months of death)  
Fall, on ice.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of January 24, 1945

Where did injury occur? (City or town) (County) (State)

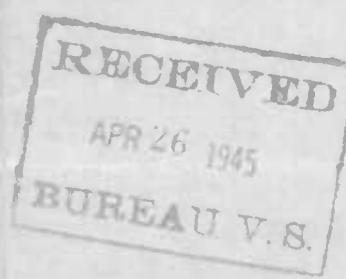
Injured at home, farm, industry, public place (where?) At home, in back yard

Means of injury Accidental fall Injured at work?

23. SIGNATURE Esther F. Kubin M.D.

M. D. or other

Address Rockville, Md Date signed 4/13/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2410

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County. Montgomery

City or town. Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred: Suburban Hospital

How long in hospital or Institution? 3 days

## 3. (a) FULL NAME

Chester F. Ritt

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ethel W. Ritt

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 15, 1908

8. AGE:

Years

Months

Days

If less than one day

36 10 28

hrs. min.

9. Birthplace

Milwaukee, Wisconsin

(Town, county, and state)

10. Usual occupation

Engineer

11. Industry or business

MOTHER

12. Name

Franklin C. Ritt

FATHER

13. Birthplace

Milwaukee, Wis.

MOTHER

14. Maiden name

Hydia Kruck

15. Birthplace

Milwaukee, Wis.

16. Informant

Hospital Records.

Address

17. Cremation

(Burial, cremation, or removal. Which?)

Date thereof, (month) (day) (year)

Cemetery or crematory

Cedar Hill Cemetery

Location

5000 Shiloh Rd.

18. Funeral director

Jos. Lawless Sons

Address

1756 Pa. Ave. NW

19. 4-15-45-18  
(Date rec'd by registrar)

118 Jones

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

District of Columbia

County Washington

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 3806 Davis Place N.W.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1945 at 12:48 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 10 1945 to April 13 1945

and that I last saw him alive on April 17 1945

Immediate cause of death

hemorrhage

Due to Rupture Esophagel Varices

Due to cirrhosis

Other conditions asites

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

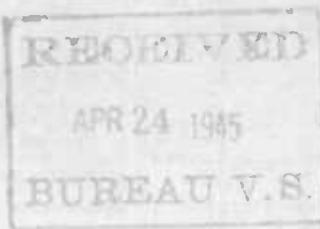
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address 1726 Eliza St. N.W. Washington 4, D.C. Date signed 4/13/45



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04691

214

## CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

## 1. PLACE OF DEATH:

County MontgomeryCity or town Rock Creek Park, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 yrsHospital, institution, or street address where death occurred: 8616 Piney Branch Rd.How long in hospital or institution? none

## 3. (a) FULL NAME

SCHOTT, ANNE CONSTANT4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife George Franklin Schott7. Birth date of deceased (mo., day, yr.) Oct 12 18708. AGE: Years 74 Months 6 Days 8 If less than one day hrs. min.9. Birthplace Peru, Indiana

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business Own home12. Name William West Constant13. Birthplace Ohio14. Maiden name Bethany Shields15. Birthplace Cincinnati, Ohio16. Informant Mrs. Nellie BerlinAddress 8616 Piney Branch Rd17. Burial (Burial, cremation, or removal, Which?) Rock Creek CemeteryDate thereof April 23, 1945  
(month) (day) (year)Cemetery or crematory Rock Creek CemeteryLocation Washington, D. C.18. Funeral director Waxner & LumpleyAddress Silver Spring, Md.19. Date rec'd by registrar Apr. 21<sup>st</sup> 1945

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty MontgomeryCity or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8616 Piney Branch Rd.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1945 at 3<sup>15</sup> M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

James 19.23 to April 20 1945and that I last saw her alive on April 17 1945Immediate cause of death Anginal Pectoris

DURATION

10 daysDue to Myocarditis

5 years

Due to High Blood Pressure, Arterio

10 years

Other conditions SclerosisArteritis

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. M. Mitchell, M.D. M. D. or otherAddress Silver Spring, Md. Date signed April 24, 1945

RECEIVED  
MAY 3 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04692

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

## 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

7119 Marion St.

How long in hospital or institution?

## 3. (a) FULL NAME

MARGARET BRUFFEY SEBRELL

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

William H. Sebrell Jr.6. (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.)

Nov 17 1907

8. AGE:

Years 37Months 8

Days

If less than one day

hrs. .... min.

9. Birthplace

Charlottesville Virginia

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name Geo. L. Bruffey13. Birthplace Albemarle Co. Virginia14. Maiden name Ida J. Faulkner15. Birthplace Albemarle Co. Virginia16. Informant Wm. H. Sebrell Jr.Address 7119 Marion St. Bethesda Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 4/24/45  
(month) (day) (year)

Cemetery or crematory

Arlington Natl. CemeteryLocation Arlington, Va.18. Funeral director John R. Reuben PumphreyAddress 7557 Eds. Ave. Bethesda19. 4/22 1945 PM 3:00  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7119 Marion St.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

~

## MEDICAL CERTIFICATION

20. DATE OF DEATH

4-21

19 45 at 11:01 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 6 1945 to 4-21 1945and that I last saw h. sr. alive on 4-20

19 45

Immediate cause of death

Pulmonary + Cardiac Failure

DURATION

72 hrs.Due to Severely Cerebral Cerebral  
(Sub-retro - R. Breast + arm)

6 mos.

Due to Metastatic carcinoma

19 45

arising in the L. breast

19 45

Other conditions Pathologic fracture of

1 year

Rt. Numerous due to metastases.

(Include pregnancy within 3 months of death)

Major findings of operations Primary Adeno carcinoma Grade IIIL. BreastDate of op. 1940

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

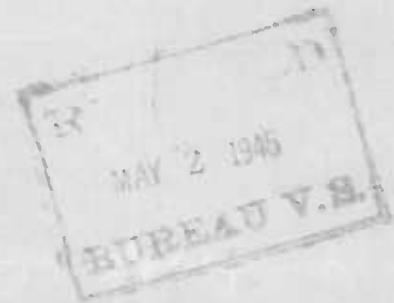
23. SIGNATURE Donald J. Birnbaum

U.S. Public Health Service

M. D. or other

Nat. Guard. Servt

Date signed 4-21-45Address Bethesda Md.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct  
percentage  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 400

04693

216

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:  
County..... Montgomery  
City or town..... Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
five days  
How long in above place of death?.....  
Hospital, Institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution?..... five days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Wash., D.C. County.....  
City or town..... (If outside city or town limits, write RURAL and give nearest town)  
Street No..... 3738 Southern Avenue, S. E.  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3.(a) FULL NAME

SIMMONDS, Harold Anthony, CRM USN Ret. Inact.

## 3.(b) Social Security Number

4. Sex..... male 5. Color or race..... 6.(a) Single, married, widowed, or divorced  
W-US married

6.(b) Name of husband or wife..... Mrs. Kathryn Simmonds

7. Birth date of deceased (mo. day, yr.)..... Aug. 22, 1900 6.(c) If alive, give age..... years

8. AGE: Years..... 44 Months..... 7 Days..... 9 If less than one day  
..... hrs. ..... min.

9. Birthplace..... N.Y. (Town, county, and state)

10. Usual occupation..... Navy

11. Industry or business

12. Name..... Joseph Simmonds

13. Birthplace..... N.Y.

14. Maiden name..... Minnie Butler

15. Birthplace..... Mass.

16. Informant..... wife: Mrs. Kathryn Simmonds  
Address..... 3738 Southern Avenue, S. E.

17. burial..... Date thereof..... 1-1-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Arlington National

Location..... Arlington, Va.

18. Funeral director..... W. W. Chambers,

Address..... 517 11th St., S. E., Wash. D.C.

19. 2 April 1945 Mary Charlotte Smith  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 1 1945 at 1:15 a.m.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from  
27 March 1945 to April 1 1945  
and that I last saw h. in alive on 31 March 1945

Immediate cause of death.....

Cancer of the Rectum c  
metastasis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations..... Cancer of Rectum c  
regional metastasis

Date of op.....

Autopsy results..... Cancer of Rectum c generalized metastasis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

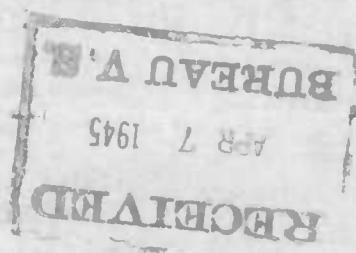
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... W. W. Chambers

M. D. or other

Address..... USN 117 Bethesda, Md. Date signed 4-3-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 750

## CERTIFICATE OF DEATH

04094

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County Montgomery  
City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Washington SanitariumHow long in hospital or institution? 2 days

## 3. (a) FULL NAME

Alma Smith

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FWh-Married

6. (b) Name of husband or wife

Mr. Le Roy Smith

7. Birth date of

deceased (mo., day, yr.) Jan. 25, 1887

8. (c) If alive, give age years

8. AGE:

Years	Months	Days	If less than one day
57	2	12	hrs. min.

9. Birthplace

Cardington, Pa.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home

MOTHER FATHER

12. Name CELESTIAN BOCK13. Birthplace PERU, N.Y.

MOTHER

14. Maiden name REGINA ROSENSTEEL

FATHER

15. Birthplace EMMITTBURG, MD.

16. Informant

Washington Sanitarium Records

Address

Takoma Park, Md.

17. BURIAL

(Burial, cremation, or removal. Which?) Burial Date thereof 1945-9-14  
(month) (day) (year)

Cemetery or crematory

ST. JOHN'S Location FOREST GLEN MONTG CO. MD.18. Funeral director Edna C. PumphreyAddress 8404 Ga Ave - Silver Spring, Md.Date rec'd by registrar Apr. 9-1945 Registrar J. Herdele

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County RockvilleCity or town Rockville (If outside city or town limits, write RURAL and give nearest town)Street No. Route #4

(If rural, give LOCATION)

2.(a) If veteran, name war

none

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 16, 194521. I CERTIFY that death occurred on the date above stated: that I attended deceased from Apr. 4, 1945, to Apr. 6, 1945, and that I last saw her alive on Apr. 6, 1945.

Immediate cause of death

Bantistis Disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

SplenomegalyDate of op. 4-6-45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Paul V. Starr, M.D.

M. D. or other

Address Takoma Park, Md. Date signed Apr. 6, 1945

RECEIVED  
APR 24 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

04095  
216

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... *Montgomery*  
 City or town..... *Bethesda*  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:

*Suburban Hospital*

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Maryland* County *Montgomery*  
 City or town..... *Silver Spring*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... *8201 Queen Anne Drive*  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## 3. (a) FULL NAME

*Nancy Lee Smith*4. Sex *Female* 5. Color or race *white widow* 6.(a) Single, married, widowed, or divorced *widow*6.(b) Name of husband or wife..... *William*7. Birth date of deceased (mo., day, yr.) *Nov. 15, 1887* 6.(c) If alive, give age ..... years8. AGE: Years *57* Months *5* Days *28* If less than one day9. Birthplace..... *Frederick, Maryland* (Town, county, and state)

10. Usual occupation.....

## 11. Industry or business

12. Name..... *George E. Prenger*13. Birthplace *MD -*14. Maiden name..... *Eckstein*15. Birthplace *MD*16. Informant..... *Hilton Smith (son)*Address *8201 Queen Anne Dr.*17. Removal Date thereof..... *4-12-45* (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director..... *W.W. Chambers Co.*Address *1400 Chapin St. N.W.*19. *4-12-45* (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *April 12* 19. *45* at *6:10 P.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *4/11/45* 19. *45* to *4/12* 19. *45*and that I last saw her alive on *4/12* 19. *45*

Immediate cause of death.....

*Coronary Occlusion*

DURATION

Due to.....

*Cerebral Haemorrhage*

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

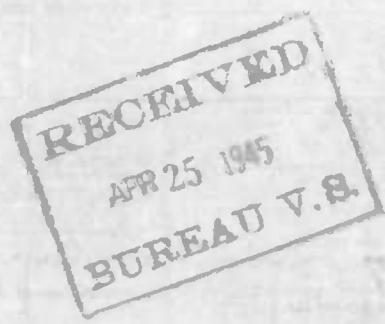
Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work? .....

23. SIGNATURE *J. A. Martz*

M. D. or other

Address *7209 Overlook Rd. N.W.* Date signed *4-12-45*



Evidence for change of  
year of birth of deceased  
is shown on

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 51-2

04096

213

## CERTIFICATE OF DEATH

Reg. Dist. No.

HLM No. G 95 JUN 8 1945

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Jacob Charles Snyder

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m

w

married

6. (b) Name of husband or wife

Mary Elizabeth Snyder7. Birth date of  
deceased (mo., day, yr.)Oct 6 - 1864 18746. (c) If alive, give age 64 years

8. AGE:

Years

Months

Days

If less than one day

70

6

20

hrs.

min.

9. Birthplace

Germantown Maryland

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

12. Name

Jacob F Snyder

13. Birthplace

Germantown

14. Maiden name

Nannie F Richter

15. Birthplace

 Maryland

16. Informant

Mrs J C Snyder

Address

Germantown Md

17. Burial

Date thereof 4 28 - 45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Rehoboth Presbyterian

Location

Rehoboth Md

18. Funeral director

B. T. Miller

Address

Baltimore Md

19. Date rec'd by registrar

April 18 - 1945

19. 45

Upton D. Bourne M.D.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State  Maryland County MontgomeryCity or town Germantown (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_ (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1945 at \_\_\_\_\_

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1945 to April 26 1945and that I last saw him alive on April 8 1945Immediate cause of death Myocardial infarctionChronic dysentery

DURATION

3 wksDue to Carcinoma of bladder 2 yrsSecondary toCarcinoma of penisambulation ceased in 1937Other conditions Transplantation of testesSecondary involvement of bladder.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

Upton D. Bourne M.D. M. D. or otherAddress Garrisonville Md Date signed 4/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

## CERTIFICATE OF DEATH

Reg. Dia. No. 216

04/29/22  
04/19/97

## 1. PLACE OF DEATH:

County.....

Montgomery

City or town.....

Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?.....

## 3. (a) FULL NAME

Janice M. Baper

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white

widower

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

74

hrs.

min.

9. Birthplace.....

Md  
(Town, county, and state)

10. Usual occupation.....

Fiber

11. Industry or business

FATHER

12. Name.....

Els Baper

13. Birthplace

Maryland

14. Maiden name.....

Mollie Baper

15. Birthplace

Maryland

16. Informant.....

Alice Baper

Address

Arlington Md.

17. Burial

Date thereof..... 4/6/45  
(month) (day) (year)

Cemetery or crematory

Montgomery Cem

Location

Belleville Md

18. Funeral director.....

Wm B Hilton

Address

Barnesville Md

19. 4/4/45

19. 45

(Date rec'd by registrar)

Wm E Jones

Register

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 3, 1945 4:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9/24 1945 to 4/3 1945  
and that I last saw h. in alive on 4/3 1945

Immediate cause of death.....

Coronary Embolism

Due to.....

Apoplectic stroke

DURATION

2 weeks

Due to.....

Cerebral Atherosclerosis

12 years

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

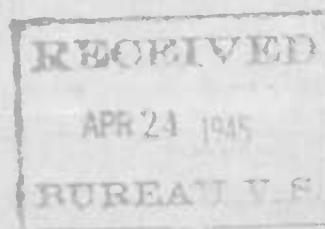
Injured at work? .....

23. SIGNATURE..... J. A. Mathis

M. D. or other

Address.....

Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

04698

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County... Montgomery

City or town... Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? 6 days

## 3. (a) FULL NAME

Annie Stoeker

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Lewis O. Stoeker (deceased)

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

Dec. 3, 1870

8. AGE:

Years  
74Months  
3Days  
15

If less than one day

hrs. min.

9. Birthplace

Saugus, Essex, Mass.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name Willard Louke Fiske

13. Birthplace Saugus, Mass.

14. Maiden name Elizabeth Williams

15. Birthplace Saugus, Mass

16. Informant Mrs. H. F. Stimson (daughter)

Address

2920 Brandywine St.

17. Removal (Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

The A. H. Hines Co

18. Funeral director

Address 2901 - 14 St. N. W. Washington, D. C.

19. 4/18 1945

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Dist. of Col. County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2920 Brandywine St.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 18th 1945 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 18, 1945, to April 18, 1945

and that I last saw her alive on

April 17th 1945

Immediate cause of death

Coronary Occlusion

Due to Coronary Sclerosis

Myocarditis

Diabetes

Other conditions Anthracis of Liver

Acute Renal Thrombosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

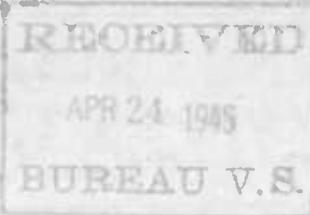
Means of Injury

Injured at work?

23. SIGNATURE

Truman Robb Jr. M. D. or other

Address 3741 Huntington Dr. Date signed 4/18/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 164-7

04699

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montg.

City or town Cherry Chase Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

4706 De Russey Pkwy.

How long in hospital or institution?

## 3. (a) FULL NAME

George Henry Van Wagner

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married

6. (b) Name of husband or wife

Florence A.

7. Birth date of

deceased (mo., day, yr.)

March 18, 1901

6. (c) If alive, give age 42 years

8. AGE:

Years

Months

Days

If less than one day

44

1

2

hrs.

min.

9. Birthplace

Lyde Park - New York

(Town, county, and state)

10. Usual occupation

Attorney at Law

11. Industry or business

George Van Wagner

12. Name

George Van Wagner

13. Birthplace

Lyde Pk. N.Y.

14. Maiden name

Sarah E. Gleeks

15. Birthplace

Lyde Park N.Y.

16. Informant

Mrs. Florence A. Van Wagner

Address

4706 De Russey Pkwy.

17. Burial

Date thereof 4/23/45

(Burial, cremation, or removal. Which?)

George Washington Memorial

Cemetery or crematory

D.C. Md. cem.

Location

Wm. Rankin Thompson

18. Funeral director

7557 Wisconsin Ave. Bethesda

Address

4/22 1945 W.E. Johns M.D.

19. (Date/rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. County Montg.

City or town

Cherry Chase Md.

Street No.

4706 De Russey Pkwy.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH April 19 45 at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

and that I last saw h. alive on 19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death heart diseasemultiple pathological reportare completeDue to The only findings were 0.2% alcoholin the brain. The heart disease determined theDue to exact cause of death Cerebr.

Other conditions

(Include pregnancy within 3 months of death)

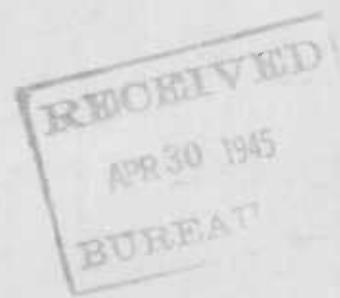
Major findings of operations

Autopsy results Report later Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:

Accident, suicide, or homicide Post mortem Date ofWhere did injury occur Cherry Chase Montg. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) near homeMeans of injury - Injured at work? no23. SIGNATURE John B. Benigni Poole M. D. or otherAddress Bethesda Md. Date signed 4/21/45



H

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

IMI

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04100

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:  
Montgomery County

City or town... Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 years

Hospital, institution, or street address where death occurred:  
308 Hancock Ave.

How long in hospital or institution? ---

3. (a) FULL NAME  
Goldsburgh Benjamin Walker

4. Sex M 5. Color or race Negro 6.(a) Single, married, widowed, or divorced  
Married

6.(b) Name of husband or wife... Rebecca E. Walker

7. Birth date of deceased (mo., day, yr.) ? 6.(c) If alive, give age ..... years

8. AGE: 79 Years Months Days If less than one day  
..... hrs. ..... min.

9. Birthplace... Markham, Va.  
(Town, county, and state)

10. Usual occupation... Janitor

11. Industry or business... Office Bldg.

MOTHER FATHER

12. Name... --

13. Birthplace... --

14. Maiden name... Mary --

15. Birthplace... --

16. Informant... Mrs. G. B. Walker

Address 308 Hancock Ave., Takoma Pk., Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory... Removal  
Location Washington, D.C.

18. Funeral director... Robert G. McGuire

Address 1820 - 9th St., N.W.

19. 4/28/45 19..... J. Wilson Dodd  
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State... Maryland County... Montgomery

City or town... Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)

Street No... 308 Hancock Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war. --

3. (b) Social Security Number --

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 28, 1945 at 6 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 1944 to April 1945 and that I last saw him alive on April 10, 1945.

Immediate cause of death... Cerebral apoplexy

DURATION 12 hrs.

Due to... Arteriosclerosis

5 yrs.

Due to... Senile degeneration

Other conditions... --

(Include pregnancy within 8 months of death)

Major findings of operations... Date of op.

Autopsy results... --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury... Injured at work?

23. SIGNATURE. \*\*\* William J. Spicer  
Attending Physician

M. D. or other

Address 703 C St., S.W. Date signed April 28, 1945

Washington, D.C.



## MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County Montgomery  
Village or City Silver Spring

Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Registration Dist. No. 460704101  
214

St.

Ward

No. 1015 Dale Drive

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2. FULL NAME Maxy Clement Watson If U. S. Veteran, specify WAR \_\_\_\_\_(a) Residence: No. 1015 Dale Drive, Silver Spring, Maryland  
(Usual place of abode)

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u>
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5a. If married, widowed, or divorced  
HUSBAND of  
& WIFE ofJames Angus Watson

6. DATE OF BIRTH (month, day, and year)

Sept. 1, 1867

7. AGE <u>77</u> Years	Months <u>9</u>	Days <u>12</u>	If LESS than 1 day, _____ hrs. or _____ min.
------------------------	-----------------	----------------	--

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Housewife</u>	11. Total time (years) spent in this occupation
--	---

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Own Home

10. Date deceased last worked at this occupation (month and year)

12. BIRTHPLACE (city or town)  
(State or country) Sunbury Pa.13. NAME David Clement14. BIRTHPLACE (city or town)  
(State or country) Sunbury Pa.15. MAIDEN NAME Sarah Jane Wellington16. BIRTHPLACE (city or town)  
(State or country) Sunbury Pa.17. INFORMANT Harold Tracer Watson  
(Address) 9109 Warren St., Linden Md.18. BURIAL, CREMATION, OR REMOVAL  
Place Rock Creek Cemetery Apr. 16 194519. UNDERTAKER Warren G. Humphrey  
(Address) Silver Spring, Md.20. FILED Apr. 15 1945 Josephine M. Schaeffer  
Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH April13 (Month)  
(Day) 1942 (Year)22. I HEREBY CERTIFY, That I attended deceased from January, 1942, to April 13, 1942. I last saw him alive on April 13, 1942; death is said to have occurred on the date stated above, at 4:45 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Cardiac Failure  
Carcroma of Stomach

Date of onset

4/3/42

6 months

Other Contributory Causes of importance:

Cholelithiasis

2 weeks

Name of operation chole Date of 4/14/42What test confirmed diagnosis? gastro X-Rays Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) W. B. Wardrop M. D.  
(Address) 943 Bonifant St.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923

## Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04102

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:  
County..... Montgomery County  
City or town..... Bethesda (Rural)

(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 mos. 16 days

Hospital, Institution, or street address where death occurred:  
U.S.N.H. Bethesda, Md.  
How long in hospital or institution? 3 mos. 16 days

3. (a) FULL NAME  
Thomas Allfree WEIR

4. Sex Male 5. Color or race US 6. (a) Single, married, widowed, or divorced  
White divorced

6. (b) Name of husband or wife..... Mrs. Margarie Quivy

7. Birth date of deceased (mo., day, yr.) January 13, 1901

8. AGE: Years 44 Months 3 Days 15 If less than one day  
hrs. ..... min. ....

9. Birthplace..... Indiana  
(Town, county, and state)

10. Usual occupation..... State Department

11. Industry or business

12. Name..... David Weir

13. Birthplace..... Indiana

14. Maiden name..... Ethel Allfree

15. Birthplace..... Pennsylvania

16. Informant..... Mr. David Weir

Address 2412 Dodge St., Omaha, Neb.

17. Removal..... Date thereof..... 4-28-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Forrest Lawn

Location..... Omaha, Neb.

18. Funeral director..... S. H. HINES, J. H. H.

Address 2901 14th St., N.W., Wash., D.C.

19. 28 April 1945 (Date rec'd by registrar) *Mary Charlotte Smith*  
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Nebraska County.....

City or town..... Omaha  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2412 Dodge St.  
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 28 April 1945, at 8:25 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
10 Jan 1945, to 28 April 1945,

and that I last saw h. in alive on 26 April 1945.

Immediate cause of death..... Pneumonia

Due to..... Lung abscess

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results..... not done  
Date of op. ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of ....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

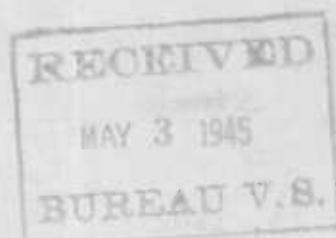
Means of injury.....

Injured at work?

23. SIGNATURE..... *C. H. Smith*

M. D. or other

Address..... U.S. Naval Hospital Bethesda, Md. Date signed 4-28-45



PLEASE WRITE PLAINLY. WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

952

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

04103

## 1. PLACE OF DEATH:

County

City or town

Montgomery  
Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

4 weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Mudge Shultz Whitneyer

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

White

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

William Whit  
meyer (deceased)

(If alive, give age) years

7. Birth date of deceased (mo., day, yr.)

Apr. 29, 1877

8. AGE:

67

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Springville, Erie, NY

(Town, county, and state)

10. Usual occupation

11. Industry or business

Chester Shultz

12. Name

Springville, NY

13. Birthplace

Weeda Muller

14. Maiden name

Ashford, NY

15. Birthplace

Mrs. Irene Saalfeld

16. Informant

6800 - 44, Ch. Ch. 15 Md

Address

Shipment

Date thereof 4/30/45  
(Burial, cremation, or removal. Which?)  
(month) (day) (year)

Cemetery or crematory

Liberty Park Cemetery

Location

Cottageagus, NY

18. Funeral director

Wm. Peckham, Humphrey

Address

7557 Wes. Ave. Bethesda,  
MD 20814

4/27

1945

Wm. E. Johnson

Registrar

4/27/45

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Montgomery

City or town Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6800 - 44 - St

(If rural, give LOCATION)

2.(a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 27, 1945, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 20, 1945, to April 27, 1945,

and that I last saw her alive on April 26, 1945.

Immediate cause of death

Coronary Occlusion

DURATION

instant

Due to Hypertension Heart

Disease

3 yrs.

Due to Arterio sclerosis

Same

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

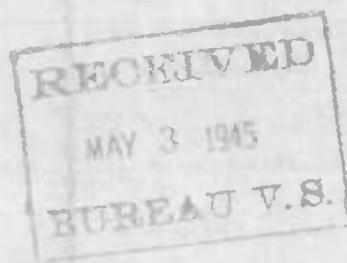
Injured at work?

23. SIGNATURE

James J. O'Donnell

M. D. or other

Address 4307 Ewingsbury Date signed 4/27/45





RECEIVED

APR 24 1945

BUREAU V.S.

(Certificate approved by Dr. Frank J. Broadhurst  
Med. Exams. Montg. Co.)